Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 5 – Thursday 8 September 2022
Monday 12 – Tuesday 13 & Thursday 15 – Friday 16 September 2022
Tuesday 20 – Wednesday 21 & Friday 23 September 2022
Monday 26 – Friday 30 September 2022

Virtual Hearing

Name of registrant:	**Michaella Jayne Dearing**
NMC PIN:	94J1003E
Part(s) of the register:	Registered Nurse – Mental Health: RNMH (October 1997)
Relevant location:	East Riding of Yorkshire
Type of case:	Misconduct
Panel members:	David Crompton (Chair, lay member) Pamela Campbell (Registrant member) Paul Leighton (Lay member)
Legal Assessor:	Michael Levy
Hearings Coordinator:	Sherica Dosunmu
Nursing and Midwifery Council:	Represented by Tom Hoskins, Case Presenter
Miss Dearing:	Not present and unrepresented
No case to answer:	**Charge 7** - Patients Q, S, X, KK **Charge 10** - Patients C, R **Charge 14** - Patients W, X
Facts proved:	**Charge 1** **Charge 2** **Charge 3** - Patients H, I, N, Q, S, U **Charge 4** - Patients A, B, C, D, E, F, H, L, N, O, Q, Y, EE, GG, MM

	Charge 6 - Patients D, H, T, FF, GG, HH, MM, NN **Charge 7** - Patients A, B, C, D, F, G, M, O, U, AA, BB, FF, GG, HH, II, LL **Charge 8** - Patients M, W, AA, BB **Charge 9** **Charge 11** **Charge 12** **Charge 13** **Charge 14** - Patients M, P, Q, R, T, U, V, Z **Charge 15** - Patient Z **Charges 16(a)**, **16(b)**, **16(c)**, **16(d)**
Facts not proved:	**Charges 4** - Patient JJ **Charge 5** **Charge 6** - Patients EE, II, JJ, KK, LL, OO, **Charge 7** - Patients L, N, P, V, W, Y, Z, EE, JJ, MM, NN, OO, **Charge 8** - Patients U, Z **Charge 10** - Patients L, O **Charge 14** - Patients K, AA **Charge 15** - Patient Y **Charge 17**
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 Miss Dearing was not in attendance and that the Notice of Hearing letter had been sent to Miss Dearing's registered email address on 1 August 2022.

Mr Hoskins, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to correspondence between Miss Dearing and the NMC from July 2018 to September 2021. He indicated that when communicating with the NMC, Miss Dearing used a second email address for a significant period after 2018, and the Notice of Hearing letter was also sent to this email address on 1 August 2022.

Mr Hoskins submitted that the NMC 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 took into account that the Notice of Hearing provided details of the allegation, the time, dates and means of joining the virtual hearing and, amongst other things, information about Miss Dearing's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Dearing 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 Miss Dearing

The panel next considered whether it should proceed in the absence of Miss Dearing. It had regard to Rule 21 and heard the submissions of Mr Hoskins.

Mr Hoskins informed the panel that a matter arose prior to the start of today's hearing, which had the potential to have an impact on the hearing proceeding as scheduled on 5 September 2022 and 6 September 2022. As a result, the NMC informed Miss Dearing on 1 September 2022 that the hearing would commence on 5 September 2022 until 11:00 and resume Tuesday afternoon on 6 September 2022. This matter was later resolved, and Miss Dearing was informed on 2 September 2022 that the hearing will proceed as initially scheduled on 5 September 2022, without an adjournment.

Mr Hoskins submitted that, although Miss Dearing has not responded to any communication from the NMC regarding the hearing schedule, he acknowledges that the NMC's recent communication sent to Miss Dearing could potentially cause some confusion as to whether the hearing would proceed on 5 September 2022. He therefore invited the panel to have a short adjournment until 6 September 2022, in order to prevent any potential confusion and to afford Miss Dearing another opportunity to engage with the NMC.

Mr Hoskins referred the panel to various correspondence between Miss Dearing and the NMC from July 2018 to September 2021. He indicated that shortly after the referral to the NMC, Miss Dearing actively engaged with the NMC regarding salient issues by email and telephone. He also informed the panel that in an email dated 1 October 2018, Miss Dearing disclosed to the NMC that [PRIVATE]. He submitted that Miss Dearing actively engaged with the NMC notwithstanding [PRIVATE]. He submitted that there has been no evidence to suggest Miss Dearing's lack of engagement in the last year is due [PRIVATE].

Mr Hoskins referred the panel to Miss Dearing's email to the NMC dated, 7 September 2021, following the NMC's Case Examiners investigation outcome, in which she stated:

> *'… i've accessed the email. I have not been practising since this process started and have no intention of ever returning to practise again and therefore would seek to request removal from register.'*

Mr Hoskins referred the panel to nine further attempts made by the NMC to contact Miss Dearing on a variety of dates following this email. He submitted that despite repeated further efforts by the NMC to contact Miss Dearing, no further response has been received from her after her email dated 7 September 2021.

Mr Hoskins stated that if Miss Dearing does not demonstrate any intention to join the hearing by Tuesday afternoon on 6 September 2022, he invites the panel to continue in her absence, on the basis that she had voluntarily absented herself. He submitted that the allegations are serious, cover a long period of time and there is clear public interest in the expeditious disposal of this case. He submitted that there has been no engagement by Miss Dearing with the NMC in relation to these proceedings for a year 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 had regard to the NMC's recent communication with Miss Dearing indicating that the hearing would commence on 5 September 2022 until 11:00 and resume Tuesday afternoon on 6 September 2022. The panel was of the view that a short adjournment until Tuesday afternoon on 6 September 2022 would be appropriate to resolve any potential confusion that may have been caused.

On 6 September 2022, the panel subsequently decided to proceed in the absence of Miss Dearing. In reaching this decision, the panel has considered the submissions of Mr Hoskins, 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 had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Dearing;
- Miss Dearing has not engaged with the NMC since 7 September 2021 and has not responded to any further correspondence from the NMC in relation to these proceedings;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Witnesses are due to give evidence, and may be caused inconvenience if there was a delay to this hearing; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Dearing in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC 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 is the consequence of Miss Dearing's decisions to absent herself from the hearing, waive her rights 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 Miss Dearing. The panel will draw no adverse inference from Miss Dearing's absence in its findings of fact.

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

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

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

Having heard that there may be reference to Miss Dearing's health, the panel determined to hold such parts of the hearing in private.

Decision and reasons on application to admit the hearsay evidence of Witness 2

The panel heard an application made by Mr Hoskins under Rule 31 to allow the written statement and exhibits of Witness 2 into evidence. The NMC made efforts to trace Witness 2, and a Trace Report was received on 23 August 2022, which indicated that Witness 2 was deceased.

Mr Hoskins submitted that Witness 2's evidence is relevant as it provides information in respect of the circumstances surrounding Miss Dearing's employment, relating to Charges 1, 2 and 14. He submitted that it would be fair to admit Witness 2's statement because it is not the sole and decisive evidence relied upon in respect of these charges. He referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. 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 2 serious consideration. The panel noted that Witness 2'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 that Witness 2 was deceased and there was public interest in the issues being explored fully, which supported the admission of this evidence into the proceedings.

The panel, in making its decision, also bore in mind the principles of relevance and fairness. The panel considered whether it would be relevant to admit the written statement and exhibits produced by Witness 2. The panel was of the view that the information provided by Witness 2 surrounding Miss Dearing's employment would be relevant in the circumstances of this case.

The panel next considered whether it would be fair to admit hearsay evidence from Witness 2 and whether Miss Dearing would be disadvantaged if this is admitted. The panel determined that it would be possible to fairly assess Witness 2's evidence and it is not the sole and decisive evidence relied upon in respect of these charges.

In these circumstances, the panel was satisfied that this evidence was relevant and that it would not be unfair to Miss Dearing if it were admitted. The panel will of course give appropriate weight to this evidence and will bear in mind that it will not be tested.

Witness 2's attendance to give live evidence

On the ninth day of the substantive hearing on 20 September 2022, it was brought to the panel's attention by Witness 1 that, to her knowledge, Witness 2 was not deceased.

In light of this information, Mr Hoskins requested a brief adjournment at the end of Witness 1's evidence, to afford the NMC a further opportunity to investigate the status of Witness 2.

On the same day it was confirmed to the panel that Witness 2 was in fact not deceased and the NMC had located the witness. Mr Hoskins informed the panel that Witness 2 would be available to give evidence the following day on 21 September 2022.

The panel heard live evidence from Witness 2 on 21 September 2022.

Decision and reasons on admissibility of further evidence

Mr Hoskins informed the panel that it was Miss Dearing's intention to provide an Inquest bundle in respect of a patient's death, to be admitted into evidence. He explained that it was Miss Dearing's position that this evidence undermines Witness 2's credibility. He referred the panel to an email from Miss Dearing dated, 2 November 2018, in which she stated:

> *'…please find enclosed the inquest information for case reference: […]. As you can see [Witness 2] the referrer to nmc not only had mislead myself in the fact that this lady was seen by Consultant within outpatient clinic appointment and was also followed up by colleague in team for 3 months prior to transfer to York. […] had claimed the opposite and this was then a significant factor in my needing to attend an interim practice hearing in London as she had stated that she had just been informed 'I had not completed paperwork for a lady who then took her life' .*'

Mr Hoskins submitted that the Inquest bundle is not admissible under Rule 31, as this is not fair or relevant. He submitted that it is the NMC's position that the Inquest documents are not relevant to any of the charges, as it is not part of the NMC case that any of the charges relate to the death of a patient. He submitted that it would not be fair to admit this Inquest bundle as it does not assist in determining the facts of this case.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application, which included Rule 31.

The panel carefully considered whether it was in a position to decide the admissibility of the Inquest bundle at this stage. Out of fairness to Miss Dearing, the panel took the view that at this stage it should not be restricted regarding the material it could potentially take into account and therefore determined to admit the Inquest bundle.

Decision and reasons on application to amend Charge 10 and 13

The panel heard an application made under Rule 28 by Mr Hoskins to amend the wording of Charge 10 and 13.

The proposed amendments were to change the wording in charge 10 from '*ensured*' to '*ensure*', and to change the wording in Charge 13 from '*24 November 2017*' to '*24 October 2017*'. Mr Hoskins submitted that the proposed amendment to charge 10 would correct a typographical error. He also submitted that it is apparent from the evidence in this matter that the date in Charge 13 is incorrect, and the proposed amendment to Charge 13 would more accurately reflect the evidence.

<u>Original Charge 10 and 13:</u>

10) Did not ensured notes were scanned on to 'Lorenzo' in a timely manner, or at all, for one or more of the patients set out in Schedule 6

13) Did not complete all required documentation in relation to a visit you made to Patient L on 24 November 2017

<u>Proposed Charge 10 and 13:</u>

10) Did not ~~ensured~~ **ensure** notes were scanned on to ‘Lorenzo’ in a timely manner, or at all, for one or more of the patients set out in Schedule 6

13) Did not complete all required documentation in relation to a visit you made to Patient L on ~~24 November 2017~~ **24 October 2017**

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

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

Details of charge (as amended)

That you, whilst employed as a Band 5 registered nurse within Humber NHS Foundation Trust, between approximately March 2016 and approximately September 2018

1. Inappropriately delegated work to Team Support Workers, “TSWs”, or allowed TSWs to complete work, which you should have completed yourself **[Proved]**

2. In July 2016, refused to issue an injection to a Patient PP **[Proved]**

3. Did not complete/ write up initial mental health assessments in a timely manner, or at all, for one or more of the patients set out in Schedule 1

   Schedule 1
   Patient H **[Proved]**
   Patient I **[Proved]**
   Patient N **[Proved]**

Patient Q **[Proved]**
Patient S **[Proved]**
Patient U **[Proved]**

4. Did not complete Risk Assessments in a timely manner, or at all, for one or more of the patients set out in Schedule 2

   Schedule 2
   Patient A **[Proved]**
   Patient B **[Proved]**
   Patient C **[Proved]**
   Patient D **[Proved]**
   Patient E **[Proved]**
   Patient F **[Proved]**
   Patient H **[Proved]**
   Patient L **[Proved]**
   Patient N **[Proved]**
   Patient O **[Proved]**
   Patient Q **[Proved]**
   Patient Y **[Proved]**
   Patient EE **[Proved]**
   Patient GG **[Proved]**
   Patient JJ **[Not Proved]**
   Patient MM **[Proved]**

5. Did not complete a CPA Review Form in a timely manner, or at all, for Patient Y **[Not Proved]**

6. Did not complete GP Letters in a timely manner, or at all, for one or more of the patients set out in Schedule 3

Schedule 3

Patient D **[Proved]**

Patient H **[Proved]**

Patient T **[Proved]**

Patient EE **[Not Proved]**

Patient FF **[Proved]**

Patient GG **[Proved]**

Patient HH **[Proved]**

Patient II **[Not Proved]**

Patient JJ **[Not Proved]**

Patient KK **[Not Proved]**

Patient LL **[Not Proved]**

Patient MM **[Proved]**

Patient NN **[Proved]**

Patient OO **[Not Proved]**

7. Did not complete Care Plans in a timely manner, or at all, for one or more of the patients set out in Schedule 4

Schedule 4

Patient A **[Proved]**

Patient B **[Proved]**

Patient C **[Proved]**

Patient D **[Proved]**

Patient F **[Proved]**

Patient G **[Proved]**

Patient L **[Not Proved]**

Patient M **[Proved]**

Patient N **[Not Proved]**

Patient O **[Proved]**

Patient P **[Not Proved]**

Patient Q **[No case to answer]**

Patient S **[No case to answer]**

Patient U **[Proved]**

Patient V **[Not Proved]**

Patient W **[Not Proved]**

Patient X **[No Case to answer]**

Patient Y **[Not Proved]**

Patient Z **[Not Proved]**

Patient AA **[Proved]**

Patient BB **[Proved]**

Patient EE **[Not Proved]**

Patient FF **[Proved]**

Patient GG **[Proved]**

Patient HH **[Proved]**

Patient II **[Proved]**

Patient JJ **[Not Proved]**

Patient KK **[No case to answer]**

Patient LL **[Proved]**

Patient MM **[Not Proved]**

Patient NN **[Not Proved]**

Patient OO **[Not Proved]**

8. Did not complete a Risk and Relapse Form in a timely manner, or at all, for one or more of the patients set out in Schedule 5

Schedule 5

Patient M **[Proved]**

Patient U **[Not Proved]**

Patient W **[Proved]**

Patient Z **[Not Proved]**

Patient AA **[Proved]**

Patient BB **[Proved]**

9. Did not complete a Falls Risk Assessment in a timely manner, or at all, for Patient A **[Proved]**

10. Did not ensure notes were scanned on to 'Lorenzo' in a timely manner, or at all, for one or more of the patients set out in Schedule 6

    Schedule 6

    Patient C **[No case to answer]**

    Patient L **[Not Proved]**

    Patient O **[Not Proved]**

    Patient R **[No case to answer]**

11. Did not complete a section '117 review' in a timely manner, or at all, for Patient B **[Proved]**

12. Did not complete paperwork relating to the initial assessment of Patient J in a timely manner, or at all **[Proved]**

13. Did not complete all required documentation in relation to a visit you made to Patient L on 24 October 2017 **[Proved]**

14. Did not visit one or more of the patients listed in Schedule 7 in a timely manner

    Schedule 7

    Patient K **[Not Proved]**

    Patient M **[Proved]**

    Patient P **[Proved]**

    Patient Q **[Proved]**

    Patient R **[Proved]**

    Patient T **[Proved]**

Patient U **[Proved]**

Patient V **[Proved]**

Patient W **[No case to answer]**

Patient X **[No case to answer]**

Patient Z **[Proved]**

Patient AA **[Not Proved]**

15. Did not take appropriate safeguarding steps in relation to one or more of the patients listed in Schedule 8

    Schedule 8

    Patient Y **[Proved]**

    Patient Z **[Proved]**

16. Did not ensure that one or more of the following were arranged/completed in respect of Patient Y;

    a. Mental Capacity Assessment; **[Proved]**
    b. Addenbrooks Test; **[Proved]**
    c. Referral to Physiotherapy or Occupational Therapy; **[Proved]**
    d. Best Interest Meeting. **[Proved]**

17. Carried out 'Transactional Analysis' with Patient AA when you were not qualified to do so. **[Proved]**

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

Decision and reasons on application of no case to answer

The panel heard an application from Mr Hoskins under Rule 24(7), that there is no case to answer in respect of Charge 7 (Schedule 4) for Patients Q, S, X, KK; Charge 10 (Schedule 6) for Patients C and R; and Charge 14 (Schedule 7) for Patients W and X.

In relation to this application, Mr Hoskins reminded the panel that the onus is on the NMC to prove its case, not Miss Dearing to prove her innocence. In discharging its duty, Mr Hoskins submitted that the documentary and witness evidence produced in this case does not substantiate the allegations in Charge 7 for Patients Q, S, X, KK; Charge 10 for Patients C and R; and Charge 14 for Patients W and X. He referred the panel to an exhibited spreadsheet outlining the evidence relied on in each charge for each patient, which generally demonstrated that the evidence relied on for these specific patients were not corroborated. He stated that the NMC did not seek to make positive submissions for the above-named patients in these charges and its respective schedule.

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

The panel had regard to Rule 24(7) which states:

> *'24(7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and—*
> *i) either upon the application of the registrant, or*
> *(ii) of its own volition, the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.'*

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

In respect of each charge, the panel considered whether there was any evidence to support the charge and each patient in its respective schedule, or whether there was some evidence, but it was of such a tenuous character that taken at its highest it could not say that the NMC had satisfied to the requisite standard that there was a case to answer.

The panel had regard to the spreadsheet produced and considered the evidence in relation to Charge 7 for Patients Q, S, X, KK; Charge 10 for Patients C and R; and Charge 14 for Patients W and X. The panel agreed with Mr Hoskin's submissions and accepted the NMC's application that there is no case to answer in relation to these charges for the above-named patients.

Background

The NMC received a referral from Humber Teaching NHS Foundation Trust (the Trust) on 26 June 2018, in relation to Miss Dearing's employment with the Trust. Miss Dearing qualified in 1997, but commenced employment with the Trust in April 2015, where she worked as a Band 5 Community Psychiatric Nurse (CPN).

The concerns raised in the referral relate to alleged deficiencies in Miss Dearing's practice as a CPN in two separate teams at the Trust. At the relevant time, Miss Dearing was initially working as a CPN at Goole Older People's Community Mental Health Team (Goole), from April 2015 until May 2018, and then Holderness Older People's Mental Health Team (Holderness), from May 2018 to June 2018. Both teams provide community mental health services for patients predominantly over the age of 65 years. Patient mental health needs were typically, but not limited to, illnesses such as Dementia, Alzheimer's, Schizophrenia, Anxiety and Depression.

In her role, Miss Dearing was responsible for coordinating the assessment, treatment, and evaluation of patients with functional mental health illnesses and progressive conditions. Miss Dearing's role as a CPN was supported by Band 3 Team Support Workers (TSW). TSWs' responsibilities involved supporting older people in the community and acting on

instructions received from CPNs. Miss Dearing's role also involved supervision from Band 6 CPN's, with regular supervision meetings where feedback and support were discussed.

It is alleged that concerns arose regarding Miss Dearing's ability to work effectively as a Band 5 CPN within six months of her commencing employment at Goole and continued after her transfer to Holderness until the end of her employment. The referral alleges that there were numerous occasions where Miss Dearing had not fulfilled her role effectively, putting several patients at risk, which involved the following:

- Not completing assessments at all or in a timely manner;
- Not completing care plans at all or in a timely manner;
- Not completing relevant documentation at all or in a timely manner;
- Not completing/carrying out reviews at all or in a timely manner;
- Not completing observations in a timely manner;
- Not completing/providing appropriate care to patients;
- Failure to action tasks from supervision.

The referral alleges that, in addition to concerns regarding general deficiencies in Miss Dearing's practice, there were also concerns relating to lack of support she offered to TSWs. It is alleged that issues were reported whereby Miss Dearing left TSWs to deal with complex situations unsupported, and delegated work she should have carried out herself.

At the time of the concerns raised in 2016, Miss Dearing informed supervising colleagues that [PRIVATE]. Miss Dearing was on sick leave from work on the following occasions:

- 22 April 2016 to12 May 2016;
- 5 July 2016 to 31 August 2016;
- 30 January 2017 to 10 February 2017;
- 22 May 2017 to 22 June 2017;
- 9 November 2017 to 2 February 2018;
- 5 June 2018 to 1 August 2018.

It is alleged that Miss Dearing's attendance at work had an impact on her ability to keep up with her caseload. Miss Dearing's caseload was therefore reduced from the usual 25 – 30 patients, to 12 – 15 patients to aid improvement in her performance. However, it is alleged that this did not improve the issues identified with Miss Dearing's practice.

On 13 July 2016, it was reported to the Trust's Human Resource (HR) department that there were issues with incomplete paperwork and delivery of care regarding patients allocated to Miss Dearing. This was raised by members of the Goole team who provided cover for Miss Dearing's caseload during her sick leave and was reported to HR by Witness 1. As a result, a full audit of Miss Dearing's caseload was carried out in September 2016, which allegedly identified multiple issues with documentation being incomplete or not present. It was also allegedly identified that on a number of occasions visits were not carried out by Miss Dearing in a timely fashion, and on one occasion safeguarding concerns were present but not acted on adequately.

An incident was reported to Witness 1 (Miss Dearing's Band 6 supervising CPN at the time), where Miss Dearing allegedly refused to administer a depot injection to a patient on 1 July 2016. As a result, Witness 1 raised the incident with Miss Dearing in a supervision meeting and offered further training. Following this meeting Miss Dearing's relationship with Witness 1 broke down and her supervision was later undertaken by Witness 4 (another Band 6 CPN at the time), from September 2016.

On 23 April 2018, Miss Dearing indicated to a colleague at the Trust that she felt subject to bullying behaviour from Witness 1 and expressed an intention to raise a formal bullying and harassment report. Miss Dearing later made a formal complaint regarding this matter.

Due to ongoing concerns about her performance, on 24 April 2018, Miss Dearing was invited to a meeting with Witness 1, Witness 2 and a representative from HR to discuss a potential capability programme. The implementation of a capability programme was designed to address Miss Dearing's alleged failure to meet the standards expected of a

Band 5 CPN. The meeting did not take place as Miss Dearing's union representative did not attend and Miss Dearing became distressed after overhearing a conversation between Witness 1, Witness 2 and the HR representative prior to the start of the meeting.

In May 2018, Miss Dearing was moved to the Holderness team within the Trust. Miss Dearing had weekly supervision meetings while employed within this team. It is alleged that during each supervision meeting within the Holderness team, missing paperwork was identified relating to Miss Dearing's caseload. A capability plan was again discussed. Miss Dearing started a period of sick leave in June 2018 and did not return to the team.

On 17 January 2019, Witness 7 (Service Manager at the Trust) commenced an investigation into the concerns raised regarding Miss Dearing's practice and failure to engage with the Trust's capability process. The investigation concluded with the recommendation that the matter be heard at a formal disciplinary hearing.

A disciplinary hearing was subsequently held on 8 and 13 May 2019, which resulted in the dismissal of Miss Dearing from the Trust on the grounds of gross misconduct.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Hoskins on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Miss Dearing.

The panel was mindful of Miss Dearing's position in respect of Witness 1. It bore in mind Miss Dearing's response to the NMC, which highlighted her grievance against Witness 1 for alleged bullying and harassment. However, Miss Dearing did not give live evidence, has not been cross-examined, nor were the panel able to question her. Accordingly, the panel determined it could attach little weight to Miss Dearing's allegations against Witness

1. Instead, the panel relied on corroboration from the evidence provided as a whole. In respect of this matter, the panel found a significant amount of evidence in support of the charges and concluded that the volume and variety of evidence presented was enough to allay any suggestion by Miss Dearing of malicious intent from Witness 1.

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: Band 6 Community Psychiatric Nurse (CPN), at Goole Older People's Community Mental Health Team, at the relevant time;

- Witness 2: Band 6 Community Psychiatric Nurse (CPN), at Goole Older People's Community Mental Health Team, at the relevant time;

- Witness 3: Band 6 Community Psychiatric Nurse (CPN), at Holderness Older People's Mental Health Team, at the relevant time;

- Witness 4: Band 6 Community Psychiatric Nurse (CPN), at Goole Older People's Community Mental Health Team, at the relevant time;

- Witness 5: Band 3 Team Support Worker (TSW), at Goole Older People's Community Mental Health Team, at the relevant time;

- Witness 6: Band 6 Occupational Therapist, at Goole Older People's Community Mental Health Team, at the relevant time;

- Witness 7: Service Manager for Adult Mental Health Inpatients, at the Trust.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC. The panel had sight of, in excess of 8000 pages of evidence relating to all the patients. Some patient notes were voluminous, in excess of 1000 pages for some patients, whereas others were far briefer.

The panel also had sight of an 82-page registrant's bundle, which contained information regarding Miss Dearing's grievance against witnesses in this case, various responses provided to the NMC, sickness records, and matters she wanted the panel to take into account. These included contextual matters, which she considered to be relevant during the period under scrutiny.

The panel took into account that Miss Dearing has not been the subject of previous regulatory concerns and is of good character.

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

Charge 1

1. Inappropriately delegated work to Team Support Workers, “TSWs”, or allowed TSWs to complete work, which you should have completed yourself

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 2 and Witness 5.

The panel considered the wording of the charge in accordance with the evidence. It interpreted the inappropriate delegation of work to TSWs to comprise of undertaking CPN tasks that should normally be assigned to a registered nurse (CPN). These included prolonged periods of visiting patients without any interim visits from a CPN, monitoring the effect of changes in medication, and continuing to visit patients whose conditions were deteriorating or not responding to treatment.

The panel considered Witness 2’s oral evidence, in which she indicated that although TSWs were given a wider remit at the relevant time, it was still considered inappropriate for TSWs to conduct a prolonged period of interim visits without patients being seen by qualified CPN’s. Witness 2 outlined the responsibilities of a CPN’s role when undertaking visits, where she explained that it was the task of a CPN to monitor patients’ progress or deterioration and observe the impact of changes in medication, and that this was inappropriate work for TSWs.

The panel also considered that the evidence of Witness 1, Witness 2 and Witness 5, was consistent in indicating that Miss Dearing allowed TSWs to complete work that she should have completed herself. The panel had regard to the period between 13 October 2017 and 3 May 2018, whereby TSWs conducted all visits to many of Miss Dearing’s allocated patients. The panel found that it was a part of Miss Dearing’s responsibilities as a CPN to conduct some of these visits herself.

The panel took into account that Miss Dearing was on sick leave within this period from 9 November 2017 to 2 February 2018. Notwithstanding Miss Dearing's absence, the panel determined that in having a reduced caseload, Miss Dearing should have been able to fulfil her responsibilities to complete at least some visits herself.

Accordingly, the panel found charge 1 proved.

Charge 2

2. In July 2016, refused to issue an injection to a Patient PP

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 4 and Witness 5. It also considered Miss Dearing's response to the NMC, in a letter dated 2 July 2018.

The panel considered the wording of the charge in accordance with the evidence, and it interpreted the word '*issue*' to mean administer in this context.

The panel considered that Witness 1, Witness 4 and Witness 5 all provided detailed accounts indicating that Miss Dearing refused to administer an injection to Patient PP, which it regarded as compelling. The panel found that Witness 1, Witness 4 and Witness 5's accounts of what happened were consistent and provided corroboration.

The panel had regard to Miss Dearing's letter, dated 2 July 2018. It noted that Miss Dearing did not deny refusing to administer an injection to Patient PP, but stated:

> '*In terms of my refusal to administer an IM injection. What is conveniently omitted is the fact that 4 weeks prior to this [PRIVATE]*.'

The panel determined that Witness 1, Witness 4 and Witness 5's evidence in this matter was clear, consistent and credible. It concluded that Miss Dearing's response letter does not negate the cogency of the witness evidence for this allegation, as she appears to accept that she refused to administer an injection to Patient PP, although she provides an explanation for this.

In these circumstances, the panel found charge 2 proved.

Charge 3

3. Did not complete/write up initial mental health assessments in a timely manner, or at all, for one or more of the patients set out in Schedule 1

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Trust's Essential Elements of Defensible Documentation Policy and the patient records for each patient set out in Schedule 1.

The panel noted that the Trust's Essential Elements of Defensible Documentation Policy, states the following:

> ***'Notes should be written contemporaneously*** *this means within 24 hours of the contact with the client'*

The panel considered this policy in conjunction with witness evidence and determined that 24 hours appeared to be generally accepted from all witnesses as the benchmark for recording written notes. However, the panel noted that the witness evidence also indicated that from a professional perspective, 24 hours is not always adhered to and practise could range from one to two weeks.

The panel considered the following evidence from Witness 1's witness statement:

> *'When a patient is allocated to a CPN the CPN must first conduct an initial assessment of the patient. This initial assessment must be completed with 10 working days of the date of allocation, in accordance with the Essential Elements of Defensible Documentation Policy, which I exhibit "JV9A". When a patient is referred the referral reflects the patient's needs. A patient's condition can change and worsen very quickly and so it is important that they are assessed quickly in order that the appropriate care and support can be provided to the patient as soon as possible. If an initial assessment is not conducted in this timeframe then there may be a delay in identifying risks to the patient, such as a risk of self-harm or suicide. I therefore consider the failure to complete an initial assessment in a timely manner and within the 10 day timeframe to be a serious matter.'*

The panel therefore took a generous view and accepted, in line with Witness 1, that notes recorded within 10 working days of allocation could be regarded as written up contemporaneously and in a timely manner, in accordance with the customs and practise of Miss Dearing's team at the time.

The panel had regard to **Schedule 1**, which included the following six patients:

- Patient H
- Patient I
- Patient N
- Patient Q
- Patient S
- Patient U

The panel considered the patient records for each patient separately.

Patient H

This charge is found proved.

The panel noted that Patient H was allocated to Miss Dearing on 13 May 2016, and Miss Dearing visited Patient H on 26 May 2016. It further noted that Miss Dearing completed an Addenbrooke's Cognitive Examination document on 17 June 2016. The panel found no other evidence of a completed mental health assessment.

The panel regarded the Addenbrooke's Cognitive Examination document as an initial assessment comprising part of an overall mental health assessment, which was not recorded by Miss Dearing until over a month after the patient had been allocated. The panel therefore determined that the mental health assessment was not written up in a timely manner for Patient H.

Accordingly, this charge is found proved.

Patient I

This charge is found proved.

The panel noted that Patient I was allocated to Miss Dearing on 28 June 2016, and Miss Dearing visited Patient I on 1 July 2016. It further noted that Miss Dearing completed a General Depression Scale form at the time of her visit on 1 July 2016. However, the panel did not regard this as an initial mental health assessment as it is not a full overview of the patient's overall condition, but only included an overview of depression. The panel found no other evidence of a completed mental health assessment.

The panel took into account that Miss Dearing went on sick leave on 5 July 2016 to 31 August 2016. However, the panel was of the view that it is reasonable to expect that an initial mental health assessment should have been completed since the patient's allocation

on 28 June 2016, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no mental health assessment was written for Patient I.

Accordingly, this charge is found proved.

Patient N

This charge is found proved.

The panel noted that Patient N was allocated to Miss Dearing on 1 November 2016, and Miss Dearing visited Patient N on 14 November 2016. It further noted that Miss Dearing completed an initial mental health assessment document on 5 January 2017.

The panel found that there was a substantial delay of over two months from the date of allocation to the completion of the initial mental health assessment. The panel therefore determined that the mental health assessment was not written up in a timely manner for Patient N.

Accordingly, this charge is found proved.

Patient Q

This charge is found proved.

The panel noted that Patient Q was allocated to Miss Dearing on 7 March 2017, and Miss Dearing visited Patient Q on 14 March 2017. It further noted that Miss Dearing completed an initial mental health assessment document on 22 March 2017.

The panel found that there was a delay of over two weeks from the date of allocation to the completion of the initial mental health assessment. The panel therefore determined that the mental health assessment was not written up in a timely manner for Patient Q.

Accordingly, this charge is found proved.

Patient S

This charge is found proved.

The panel noted that Patient S was allocated to Miss Dearing on 11 January 2016, and Miss Dearing visited Patient S on 26 January 2016. It further noted that a MHCT – Patient Assessment Form featured notes from Miss Dearing on 26 January 2016. The panel found no other evidence of a completed mental health assessment by Miss Dearing. However, the panel found that the General Practitioner's (GP) letter following this assessment indicated that the work was not received until 12 February 2016.

The panel was minded to regard the MHCT – Patient Assessment Form document as an initial mental health assessment. Nevertheless, it considered that this document was not completed by Miss Dearing until over a month after the patient had been allocated. The panel therefore determined that the mental health assessment was not written up in a timely manner for Patient S.

Accordingly, this charge is found proved.

Patient U

This charge is found proved.

The panel noted that Patient U was allocated to Miss Dearing on 8 January 2016, and Miss Dearing visited Patient U on 21 January 2016. It further noted that Miss Dearing completed an initial mental health assessment document on 21 January 2016.

The panel found that there was a delay of almost two weeks from the date of allocation to the completion of the initial mental health assessment. The panel therefore determined that the mental health assessment was not written up in a timely manner for Patient U.

Accordingly, this charge is found proved.

Charge 4

4. Did not complete Risk Assessments in a timely manner, or at all, for one or more of the patients set out in Schedule 2

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Trust's Essential Elements of Defensible Documentation Policy and the patient records for each patient set out in Schedule 2.

The panel took into account its reasoning in Charge 3 for its interpretation of a timely manner in this context.

The panel had regard to **Schedule 2**, which included the following 16 patients:

- Patient A
- Patient B
- Patient C
- Patient D
- Patient E
- Patient F
- Patient H
- Patient L
- Patient N
- Patient O

- Patient Q
- Patient Y
- Patient EE
- Patient GG
- Patient JJ
- Patient MM

The panel considered the patient records for each patient separately.

Patient A

This charge is found proved.

The panel noted that Patient A was allocated to Miss Dearing on 5 October 2017 and remained on her caseload until 16 May 2018.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed since the patient's allocation on 5 October 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient A.

Accordingly, this charge is found proved.

Patient B

This charge is found proved.

The panel noted that Patient B was allocated to Miss Dearing on 18 August 2017 and remained on her caseload until November 2017.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017 to 2 February 2018. However, the panel was of the view that it is reasonable to expect that a risk assessment should have been completed since the patient's allocation on 18 August 2017, in a timely manner, before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient B.

Accordingly, this charge is found proved.

Patient C

This charge is found proved.

The panel noted that Patient C was allocated to Miss Dearing on 3 May 2017 and remained on her caseload until November 2017.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 22 May 2017 to 22 June 2017 and again on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed since the patient's allocation on 3 May 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient C.

Accordingly, this charge is found proved.

Patient D

This charge is found proved.

The panel noted that Patient D was allocated to Miss Dearing on 3 May 2017, remained on her caseload until her sick leave on 22 May 2017 and was later reallocated at the end of May 2017.

The panel considered that Miss Dearing's completed mental health assessment on 8 May 2017 featured a summary of the patient's risks, which consisted of two bullet points. However, the panel did not regard this as a completed risk assessment. The panel found no other documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 22 May 2017. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 3 May 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient D.

Accordingly, this charge is found proved.

Patient E

This charge is found proved.

The panel noted that Patient E was allocated to Miss Dearing on 28 March 2017, remained on her caseload until her sick leave on 22 May 2017 and was later reallocated at the end of May 2017.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 22 May 2017. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 28 March 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient E.

Patient F

This charge is found proved.

The panel noted that Patient F was allocated to Miss Dearing on 17 January 2017 and later discharged from the Goole Inpatient Unit on 31 January 2017. It also noted that Patient F remained allocated to Miss Dearing, as patients still require regular reviews after being discharged from the Goole's Inpatient Unit.

The panel considered Patient F's discharge summary dated 13 February 2017, which stated the following:

> *'CPN Michaela Dearing to complete 7 day follow up and offer ongoing support as part of CMHT.'*

The panel had regard to a document titled Working Age Mental Health and Older People's Community Mental Health – Risk Management and Enablement Plan, completed by a member of Trust staff on 2 March 2017 and counter signed by Miss Dearing. The panel was minded to regard the Working Age Mental Health and Older People's Community Mental Health – Risk Management and Enablement Plan document as a risk assessment. Nevertheless, it considered that this document was not completed until over two weeks

after Patient F's discharge summary, which indicated that a follow up should have taken place within seven days. The panel therefore determined that the risk assessment was not completed in a timely manner for Patient F.

Accordingly, this charge is found proved.

Patient H

This charge is found proved.

The panel noted that Patient H was allocated to Miss Dearing on 13 May 2016 and remained on her caseload until 2 August 2016.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 4 July 2016 to 31 August 2016. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 13 May 2016, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient H.

Accordingly, this charge is found proved.

Patient L

This charge is found proved.

The panel noted that Patient L was allocated to Miss Dearing on 14 September 2017, remained on her caseload until her sick leave on 9 November 2017 and was later reallocated in November 2017.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 14 September 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient L.

Accordingly, this charge is found proved.

Patient N

This charge is found proved.

The panel noted that Patient N was allocated to Miss Dearing on 1 November 2016.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing. The panel determined that no risk assessment was completed for Patient N.

Accordingly, this charge is found proved.

Patient O

This charge is found proved.

The panel noted that Patient A was allocated to Miss Dearing on 18 August 2017 and remained on her caseload until April 2018.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 18 August 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient O.

Accordingly, this charge is found proved.

Patient Q

This charge is found proved.

The panel noted that Patient Q was allocated to Miss Dearing on 7 March 2017 and remained on her caseload until May 2017.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 22 May 2017 to 22 June 2017. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 7 March 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient Q.

Accordingly, this charge is found proved.

Patient Y

This charge is found proved.

The panel noted that Patient Y was allocated to Miss Dearing on 14 February 2017 and remained on her caseload until May 2018.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 22 May 2017 to 22 June 2017 and on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 14 February 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient Y.

Accordingly, this charge is found proved.

Patient EE

This charge is found proved.

The panel noted that Patient EE was allocated to Miss Dearing on 22 May 2018.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave from 4 June 2018. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 22 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient EE.

Accordingly, this charge is found proved.

Patient GG

This charge is found proved.

The panel noted that Patient GG was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 20 June 2018.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave from 4 June 2018. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient GG.

Accordingly, this charge is found proved.

Patient JJ

This charge is found NOT proved.

The panel noted that a document titled MDT Meeting Record, dated 29 May 2018, indicated that Patient JJ would be allocated to Miss Dearing. However, the panel found that the patient records for Patient JJ contained an absence of notes from 22 May 2018 onwards and had no information as to who the patient's care provider was.

Therefore, although the panel found no documentary evidence of a risk assessment completed by Miss Dearing, it was not persuaded that Miss Dearing had full ownership of this patient at the relevant time.

In the absence of any further evidence, the panel found this charge not proved.

Patient MM

This charge is found proved.

The panel noted that Patient MM was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 20 June 2018.

The panel considered an entry in the notes from Miss Dearing on a Nursing Communication Sheet, dated 21 May 2018, which includes the statement *'thoughts of suicide'*. The panel is of the view that this should have warranted an immediate risk assessment.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave from 4 June 2018. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed since following patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no risk assessment was completed for Patient MM.

Accordingly, this charge is found proved.

Charge 5

5. Did not complete a CPA Review Form in a timely manner, or at all, for Patient Y

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Care Plan Approach (CPA) and Non-CPA Policy and Procedural Guidance and patient records for Patient Y.

The panel noted that Patient Y was allocated to Miss Dearing on 14 February 2017 and she designated Patient Y as a case managed patient.

The panel took into account the Care Plan Approach (CPA) and Non-CPA Policy and Procedural Guidance.

> *'… for service users who have care organised through case management however there is not the same requirement of a formalised care plan and risk and relapse plan…'*

The panel had regard to Witness 1's evidence in her written witness statement, in which she makes the following distinction:

> '*There are two approaches to a person's care, which are 'case managed' and Care Plan Approach ("CPA"). Case managed patients are generally lower risk, short term patients that are expected to be discharged after a few months. CPA patients are more complex and have other care professionals involved in their care.*
>
> *CPA Review Forms contain factual information in relation to the patient, such as who the patients GP is and the patient's next of kin. The CPA Review Form formalises the acknowledgement that other individuals are involved in the individuals care.'*

The panel noted that, in her oral evidence, Witness 1 outlined risk factors that she felt warranted Patient Y's case to be dealt with as CPA. However, the panel further noted that Witness 1 confirmed in her oral evidence that it was the decision of the assigned CPN at the time to determine whether a patient is classified as case managed or CPA.

The panel considered that Patient Y was assessed as a case managed patient, and although Witness 1 felt Patient Y should have been dealt with as CPA, the decision belonged to the CPN at the time.

The panel therefore concluded that as a case managed patient, Miss Dearing was therefore not required to complete a CPA Review Form.

Accordingly, the panel found charge 5 not proved.

Charge 6

6. Did not complete GP Letters in a timely manner, or at all, for one or more of the patients set out in Schedule 3

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Trust's Essential Elements of Defensible Documentation Policy and the patient records for each patient set out in Schedule 3.

The panel took into account its reasoning in Charge 3 for its interpretation of a timely manner in this context.

The panel had regard to **Schedule 3**, which included the following 14 patients:

- Patient D

- Patient H
- Patient T
- Patient EE
- Patient FF
- Patient GG
- Patient HH
- Patient II
- Patient JJ
- Patient KK
- Patient LL
- Patient MM
- Patient NN
- Patient OO

The panel considered the patient records for each patient separately.

Patient D

This charge is found proved.

The panel noted that Patient D was allocated to Miss Dearing on 3 May 2017, remained on her caseload until her sick leave on 22 May 2017 and was later reallocated at the end of May 2017. It further noted that Miss Dearing completed an initial mental health assessment document on 8 May 2017.

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 22 May 2017. However, the panel was of the view that it was reasonable to expect that a GP letter should have been completed following the patient's allocation on 3 May 2017, in a timely

manner before the date Miss Dearing went on sick leave. The panel determined that no GP letter was completed for Patient D.

Accordingly, this charge is found proved.

Patient H

This charge is found proved.

The panel noted that Patient H was allocated to Miss Dearing on 13 May 2016, remained on her caseload until after her sick leave on 5 July 2016 and was reallocated on 2 August 2016. It further noted that Miss Dearing completed an Addenbrooke's Cognitive Examination for Patient H on 17 June 2016.

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 5 July 2016 to 31 August 2016. However, the panel was of the view that it was reasonable to expect that a GP letter should have been completed following the patient's allocation on 13 May 2016, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no GP letter was completed for Patient H.

Accordingly, this charge is found proved.

Patient T

This charge is found proved.

The panel noted that Patient T was allocated to Miss Dearing on 22 January 2016, remained on her caseload until 3 March 2016. It further noted that Miss Dearing

completed an initial mental health assessment document on 4 February 2016 and a GP letter on 6 March 2016.

The panel found that there was a delay of over six weeks from the date of the allocation to Miss Dearing's completion of the GP letter. The panel therefore determined that the GP letter was not completed in a timely manner for Patient T.

Accordingly, this charge is found proved.

Patient EE

This charge is found NOT proved.

The panel noted that Patient EE was allocated to Miss Dearing on 22 May 2018. It further noted that a GP letter was completed on 24 May 2018 by a Locum Consultant Psychiatrist within the Holderness team.

The panel had regard to the following, as stated in the GP letter dated 24 May 2018:

> '*Michaella Dearing, CPN has seen him today and has discussed with me her assessment findings.'*

The panel was satisfied that Miss Dearing was aware that a GP letter was written for Patient EE on 24 May 2018. Although Miss Dearing was not the one who completed the GP letter on 24 May 2018, the panel concluded that there was no evidence that Miss Dearing was required to complete another GP letter for Patient EE.

In these circumstances, the panel found this charge not proved.

Patient FF

This charge is found proved.

The panel noted that Patient FF was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 20 June 2018.

The panel found no documentary evidence of a GP letter completed by Miss Dearing. The panel determined that no GP letter was completed for Patient FF.

Accordingly, this charge is found proved.

Patient GG

This charge is found proved.

The panel noted that Patient GG was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 20 June 2018.

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. However, the panel was of the view that it was reasonable to expect that a GP letter should have been completed following the patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no GP letter was completed for Patient GG.

Accordingly, this charge is found proved.

Patient HH

This charge is found proved.

The panel noted that Patient HH was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 18 June 2018.

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. However, the panel was of the view that it was reasonable to expect that a GP letter should have been completed following the patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no GP letter was completed for Patient HH.

Accordingly, this charge is found proved.

Patient II

This charge is found NOT proved.

The panel noted that Patient II was allocated to Miss Dearing on 22 May 2018 and remained on her caseload until 20 June 2018.

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. The panel considered that Patient II was allocated to Miss Dearing for less than two full working weeks before her last day at Holderness.

Therefore, although the panel found no documentary evidence of a GP letter completed by Miss Dearing, it was not satisfied that the timeframe from allocation to Miss Dearing's last day at work could be regarding as untimely.

In these circumstances, the panel found this charge not proved.

Patient JJ

This charge is found NOT proved.

The panel noted that Patient JJ was allocated to Miss Dearing on 31 May 2018 and remained on her caseload until 20 June 2018.

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. The panel considered that Patient JJ was allocated to Miss Dearing for less than two full working weeks before her last day at Holderness.

Therefore, although the panel found no documentary evidence of a GP letter completed by Miss Dearing, it was not satisfied that the timeframe from allocation to Miss Dearing's last day at work could be regarding as untimely.

In these circumstances, the panel found this charge not proved.

Patient KK

This charge is found NOT proved.

The panel noted that Patient KK was allocated to Miss Dearing on 16 May 2018 and remained on her caseload until 20 June 2018.

The panel found no documentary evidence of a GP letter completed by Miss Dearing. However, the panel considered that Miss Dearing visited Patient KK on 31 May 2018 and left the following note in a Nursing Communication Sheet document on the same day:

‘To discuss with medic Tuesday MDT or sooner if required before any further increase to 20mg.’

In addition, the panel considered the following note was written by another Trust staff member in a Nursing Communication Sheet document, dated 5 June 2018:

‘*Discussed with Dr […], he checked his letter to the GP and stated the instructions about the haloperidol are in there and it has been received as the shared care protocol has been returned.’*

The panel was satisfied that this provided evidence that a GP letter was completed following Miss Dearing’s visit.

In these circumstances, the panel found this charge not proved.

Patient LL

This charge is found NOT proved.

The panel noted that Patient LL was allocated to Miss Dearing on 17 May 2018. It further noted that a GP letter was completed on 22 May 2018 by a Locum Consultant Psychiatrist within the Holderness team.

The panel had regard to the following, as stated in the GP letter dated 22 May 2018:

‘*Michaella Dearing CPN will discuss with her daughter about her assessment findings and medication advice.’*

The panel was satisfied that Miss Dearing was aware that a GP letter was written for Patient LL on 22 May 2018. Although Miss Dearing was not the one who completed the

GP letter on 22 May 2018, the panel concluded that there was no evidence that Miss Dearing was required to complete another GP letter for Patient LL.

In these circumstances, the panel found this charge not proved.

Patient MM

This charge is found proved.

The panel noted that Patient MM was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 20 June 2018.

The panel considered an entry in the notes from Miss Dearing on a Nursing Communication Sheet, dated 21 May 2018, which includes the statement '*thoughts of suicide'*. The panel is of the view that this should have warranted an immediate GP letter.

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. However, the panel was of the view that it was reasonable to expect that a GP letter should have been completed following the patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no GP letter was completed for Patient MM.

Accordingly, this charge is found proved.

Patient NN

This charge is found proved.

The panel noted that Patient NN was allocated to Miss Dearing on 22 May 2018 and remained on her caseload until 13 June 2018.

The panel considered an entry in the notes from Miss Dearing on a Nursing Communication Sheet, dated 29 May 2018, which includes the statement '*CPN to liaise with GP to obtain blood results*.'

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. However, the panel was of the view that it was reasonable to expect that a risk assessment should have been completed following the patient's allocation on 22 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no GP letter was completed for Patient MM.

Accordingly, this charge is found proved.

Patient OO

This charge is found NOT proved.

The panel noted that Patient OO was allocated to Miss Dearing on 22 May 2018 and remained on her caseload until 20 June 2018.

The panel found no documentary evidence of a GP letter completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. The panel considered that Patient OO was allocated to Miss Dearing for less than two full working weeks before her last day at Holderness.

Therefore, although the panel found no documentary evidence of a GP letter completed by Miss Dearing, it was not satisfied that the timeframe from allocation to Miss Dearing's last day at work could be regarding as untimely.

In these circumstances, the panel found this charge not proved.

Charge 7

7. Did not complete Care Plans in a timely manner, or at all, for one or more of the patients set out in Schedule 4

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Care Plan Approach (CPA) and Non-CPA Policy and Procedural Guidance, Trust's Essential Elements of Defensible Documentation Policy and the patient records for each patient set out in Schedule 4.

The panel took into account its reasoning in Charge 3 for its interpretation of a timely manner in this context.

The panel had regard to Witness 1's evidence in her written witness statement, in which she makes the following distinction:

> '*There are two approaches to a person's care, which are 'case managed' and Care Plan Approach ("CPA"). Case managed patients are generally lower risk, short term patients that are expected to be discharged after a few months. CPA patients are more complex and have other care professionals involved in their care.'*

The panel noted that, in her oral evidence, Witness 1 clarified that CPA patients required the completion of a care plan, whereas case managed patients did not.

The panel had regard to **Schedule 4**, which included the following 28 patients:

- Patient A
- Patient B
- Patient C
- Patient D
- Patient F
- Patient G
- Patient L
- Patient M
- Patient N
- Patient O
- Patient P
- Patient U
- Patient V
- Patient W
- Patient Y
- Patient Z
- Patient AA
- Patient BB
- Patient EE
- Patient FF
- Patient GG
- Patient HH
- Patient II
- Patient JJ
- Patient LL
- Patient MM
- Patient NN

- Patient OO

The panel considered the patient records for each patient separately.

Patient A

This charge is found proved.

The panel noted that Patient A was allocated to Miss Dearing on 5 October 2017 and remained on her caseload until 1 May 2018. It further noted that Patient A was designated as CPA on 12 October 2017.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient A.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed since the patient's allocation on 5 October 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient A.

Accordingly, this charge is found proved.

Patient B

This charge is found proved.

The panel noted that Patient B was allocated to Miss Dearing on 18 August 2017 and remained on her caseload until November 2017. It further noted that a Care Review Form

dated 7 February 2017, indicated that Patient B was designated as CPA and stated '*CPA continuing*' prior to the patient's allocation to Miss Dearing.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient B.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 18 August 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient B.

Accordingly, this charge is found proved.

Patient C

This charge is found proved.

The panel noted that Patient C was allocated to Miss Dearing on 3 May 2017 and remained on her caseload until November 2017. It further noted that Patient C was designated as CPA on 8 May 2017.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient C.

The panel found that a care plan was completed by Miss Dearing in November 2017.

The panel took into account that Miss Dearing went on sick leave on 22 May 2017 to 22 June 2017. However, the panel was of the view that it was reasonable to expect that a

care plan should have been completed following the patient's allocation on 3 May 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel therefore determined that the care plan was not completed in a timely manner for Patient C.

Accordingly, this charge is found proved.

Patient D

This charge is found proved.

The panel noted that Patient D was allocated to Miss Dearing on 3 May 2017 and remained on her caseload until July 2017. It further noted that Patient D was designated as CPA on 8 May 2017.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient D.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 22 May 2017 to 22 June 2017. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 3 May 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient D.

Accordingly, this charge is found proved.

Patient F

This charge is found proved.

The panel noted that Patient F was allocated to Miss Dearing on 17 January 2017 and later discharged from the Goole Inpatient Unit on 31 January 2017. It further noted that Patient F was designated as CPA on 8 January 2017. The panel considered that Patient F remained allocated to Miss Dearing, and patients still require regular reviews after being discharged from the Goole's Inpatient Unit.

The panel had regard to Patient F's discharge summary dated 13 February 2017, which stated the following:

> *'CPN Michaela Dearing to complete 7 day follow up and offer ongoing support as part of CMHT.'*

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient F.

The panel found no documentary evidence of a care plan completed by Miss Dearing. The panel determined that no care plan was completed for Patient F.

Accordingly, this charge is found proved.

Patient G

This charge is found proved.

The panel noted that Patient G was allocated to Miss Dearing on 22 September 2017 and remained on her caseload until May 2018. It further noted that a Care Review Form dated 19 October 2017, indicated that Patient G was designated as CPA and stated, '*CPA continuing*'.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient A.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 22 September 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient G.

Accordingly, this charge is found proved.

Patient L

This charge is found NOT proved.

The panel noted that Patient L was allocated to Miss Dearing on 14 September 2017 and remained on her caseload until May 2018. It further noted that Patient L was designated as a case managed patient on 18 September 2017.

The panel concluded that as a case managed patient, Miss Dearing was therefore not required to complete a care plan.

Accordingly, this charge is found not proved.

Patient M

This charge is found proved.

The panel noted that Patient M was allocated to Miss Dearing in October 2016 and remained on her caseload until May 2018. It further noted that a care plan was completed by Witness 1 on 28 October 2016, which indicated that Patient M was designated as CPA.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient M. The panel also considered that the care plan completed by Witness 1 stated that a review of the care plan is required in six months, that being 28 February 2017.

The panel found no documentary evidence of a care plan completed by Miss Dearing in the relevant period. The panel determined that there was a care plan inherited by Miss Dearing, which required a review, and this was not completed for Patient M.

Accordingly, this charge is found proved.

Patient N

This charge is found NOT proved.

The panel noted that Patient N was allocated to Miss Dearing on 1 November 2016. It further noted that Patient L was designated as a case managed patient on 14 November 2016.

The panel concluded that as a case managed patient, Miss Dearing was therefore not required to complete a care plan.

Accordingly, this charge is found not proved.

Patient O

This charge is found proved.

The panel noted that Patient O was allocated to Miss Dearing on 18 August 2017 and remained on her caseload until April 2018. It further noted that there were various Care

Review Forms predating the patient's allocation to Miss Dearing, which indicated that Patient O was designated as CPA.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient O.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 18 August 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient O.

Accordingly, this charge is found proved.

Patient P

This charge is found NOT proved.

The panel noted that Patient P was allocated to Miss Dearing on 8 November 2016 and remained on her caseload until May 2018. It further noted that Patient P was designated as a case managed patient on 17 November 2016.

The panel concluded that as a case managed patient, Miss Dearing was therefore not required to complete a care plan.

Accordingly, this charge is found not proved

Patient U

This charge is found proved.

The panel noted that Patient U was allocated to Miss Dearing on 8 January 2016 and remained on her caseload until 14 July 2016. It further noted that Patient U was designated as CPA on 21 January 2016.

The panel considered that Miss Dearing was required to complete a care plan for Patient U as a CPA patient.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 22 April 2016 to 12 May 2016 and again on 5 July 2016 to 31 August 2016. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 8 January 2016, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient U.

Accordingly, this charge is found proved.

Patient V

This charge is found NOT proved.

The panel noted that Patient V was allocated to Miss Dearing on 16 January 2016 and remained on her caseload until June 2016. It further noted that Patient V was designated as case managed on 3 March 2016.

The panel concluded that as a case managed patient, Miss Dearing was therefore not required to complete a care plan.

Accordingly, this charge is found not proved

Patient W

This charge is found NOT proved.

The panel noted that Patient W was allocated to Miss Dearing on 3 March 2016, remained on her caseload until 26 June 2016, and was later reallocated back to Miss Dearing on 24 November 2016. It further noted that Patient W was designated as a case managed patient on 26 February 2016.

The panel had regard to a risk assessment review completed by Miss Dearing on 17 June 2016, where the patient's designation did not change from case managed.

The panel concluded that as a case managed patient, Miss Dearing was therefore not required to complete a care plan.

Accordingly, this charge is found not proved

Patient Y

This charge is found NOT proved.

The panel noted that Patient Y was allocated to Miss Dearing on 14 February 2017 and remained on her caseload until May 2018. It further noted that Patient Y was designated as a case managed patient on 17 February 2017.

The panel concluded that as a case managed patient, Miss Dearing was therefore not required to complete a care plan.

Accordingly, this charge is found not proved

Patient Z

This charge is found NOT proved.

The panel noted that Patient Z was allocated to Miss Dearing on 21 January 2016 and remained on her caseload until 2 August 2016. It further noted that Patient Z was designated as a case managed on 21 January 2016.

The panel concluded that as a case managed patient, Miss Dearing was therefore not required to complete a care plan.

Accordingly, this charge is found not proved

Patient AA

This charge is found proved.

The panel noted that Patient AA was allocated to Miss Dearing on 7 June 2016 and remained on her caseload until 2 August 2016. It further noted that Patient AA was designated as CPA on 8 June 2016.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient AA.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 5 July 2016 to 31 August 2016. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 7 June 2016, in

a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient AA.

Accordingly, this charge is found proved.

Patient BB

This charge is found proved.

The panel noted that Patient BB was allocated to Miss Dearing on 13 April 2015 and remained on her caseload until May 2016. It further noted that Patient BB was designated as CPA on 24 June 2015.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient BB.

The panel found no documentary evidence of a care plan completed by Miss Dearing. The panel determined that no care plan was completed for Patient BB.

Accordingly, this charge is found proved.

Patient EE

This charge is found NOT proved.

The panel noted that Patient EE was allocated to Miss Dearing on 22 May 2018 and remained on her caseload until June 2016. However, the panel found that the patient records for Patient EE contained an absence of notes from 31 May 2018 onwards and had no information as to whether the patient was CPA or case managed.

Therefore, although the panel found no documentary evidence of a care plan completed by Miss Dearing, it found no evidence that this was required at the relevant time.

In the absence of any further evidence, the panel found this charge not proved.

Patient FF

This charge is found proved.

The panel noted that Patient FF was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 20 June 2018. It further noted that a MDT Meeting Record document, dated 22 May 2018 indicated that Patient FF was designated as CPA.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient FF.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave after 4 June 2018. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient FF.

Accordingly, this charge is found proved.

Patient GG

This charge is found proved.

The panel noted that Patient GG was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 18 June 2018. It further noted that a Nursing Communication Sheet dated 24 May 2018, indicated that Patient GG was designated as CPA.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient GG.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave after 4 June. However, the panel is of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient GG.

Accordingly, this charge is found proved.

Patient HH

This charge is found proved.

The panel noted that Patient HH was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 18 June 2018. It further noted that a MDT Meeting Record document, dated 22 May 2018 indicated that Patient HH was designated as CPA.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient HH.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave after 4 June 2018. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient HH.

Accordingly, this charge is found proved.

Patient II

This charge is found proved.

The panel noted that Patient II was allocated to Miss Dearing on 22 May 2018 and remained on her caseload until 20 June 2018. It further noted that a MDT Meeting Record document, dated 5 June 2018, which indicated that Patient II was designated as CPA.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient II.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave after 4 June 2018. However, the panel is of the view that it is reasonable to expect that a care plan should have been completed following the patient's allocation on 22 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient II.

Accordingly, this charge is found proved.

Patient JJ

This charge is found NOT proved.

The panel noted that Patient JJ was allocated to Miss Dearing on 28 May 2018 and remained on her caseload until 20 June 2018. It further noted that Miss Dearing completes a CPA Review Form on 29 May 2018, which indicates that Patient JJ is designated as CPA.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. The panel considered that Patient JJ was allocated to Miss Dearing for less than two full working weeks before her last day at Holderness.

Therefore, although the panel found no documentary evidence of a care plan completed by Miss Dearing, it was not satisfied that the timeframe from allocation to Miss Dearing's last day at work could be regarded as untimely.

In these circumstances, the panel found this charge not proved.

Patient LL

This charge is found proved.

The panel noted that Patient LL was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 20 June 2018. It further noted that Miss Dearing completes a CPA Review Form on 17 May 2018, which indicates that Patient LL is designated as CPA.

The panel considered that as a CPA patient, Miss Dearing was required to complete a care plan for Patient LL.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave after 4 June 2018. However, the panel was of the view that it was reasonable to expect that a care plan should have been completed following the patient's allocation on 17 May 2018, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient LL.

Accordingly, this charge is found proved.

Patient MM

This charge is found NOT proved.

The panel noted that Patient MM was allocated to Miss Dearing on 17 May 2018 and remained on her caseload until 20 June 2018. It further noted that Patient MM's patient records shows that the patient was designated as CPA prior to allocation to Miss Dearing's caseload, was case managed when allocated to Miss Dearing although designated as CPA again after the patient was reallocated.

The panel concluded that as a case managed patient whilst in Miss Dearing's caseload, Miss Dearing was not required to complete a care plan.

Accordingly, this charge is found not proved

Patient NN

This charge is found NOT proved.

The panel noted that Patient NN was allocated to Miss Dearing on 22 May 2018 and remained on her caseload until 20 June 2018. It further noted that Patient NN was designated as CPA on 29 May 2018.

The panel found no documentary evidence of a care plan completed by Miss Dearing.

The panel took into account that Miss Dearing was on sick leave after 4 June 2018. The panel considered that Patient NN was assigned as CPA less than two full working weeks before Miss Dearing's last day at Holderness.

Therefore, although the panel found no documentary evidence of a care plan completed by Miss Dearing, it was not satisfied that the timeframe from when the patient was assigned CPA to Miss Dearing's last day at work could be regarding as untimely.

In these circumstances, the panel found this charge not proved.

Patient OO

This charge is found NOT proved.

The panel noted that Patient OO was allocated to Miss Dearing on 22 May 2018 and remained on her caseload until 20 June 2018. It further noted that Miss Dearing completed a CPA Review Form on 30 May 2018, which indicates that Patient OO was designated as CPA.

The panel found no documentary evidence of a care plan completed by Miss Dearing. However, the panel considered that on Patient OO's CPA review form, dated 30 May 2018, it is stated that there is a plan to discuss this patient's discharge from Miss Dearing's caseload.

The panel was therefore not satisfied that Miss Dearing was required to complete a care plan during the time Patient OO was allocated to her.

In these circumstances, the panel found this charge not proved.

Charge 8

8. Did not complete a Risk and Relapse Form in a timely manner, or at all, for one or more of the patients set out in Schedule 5

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Trust's Essential Elements of Defensible Documentation Policy and the patient records for each patient set out in Schedule 5.

The panel took into account its reasoning in Charge 3 for its interpretation of a timely manner in this context.

The panel had regard to **Schedule 5**, which included the following six patients:

- Patient M
- Patient U
- Patient W
- Patient Z
- Patient AA
- Patient BB

The panel considered the patient records for each patient separately.

<u>Patient M</u>

This charge is found proved.

The panel noted that Patient M was allocated to Miss Dearing in October 2016 and remained on her caseload until May 2018. It further noted that a Risk and Relapse Form was completed by Witness 1 on 28 August 2016 prior to Patient M's allocation to Miss Dearing.

The panel considered that on the Risk and Relapse Form completed by Witness 1 it is stated that a CPA review would be required in six months, that being 28 February 2017.

The panel found no documentary evidence of a Risk and Relapse Form completed by Miss Dearing throughout the time Patient M was allocated to her. The panel determined that there was a Risk and Relapse Form inherited by Miss Dearing, which required a review, and this was not completed for Patient M.

Accordingly, this charge is found proved.

Patient U

This charge is found NOT proved.

The panel noted that Patient U was allocated to Miss Dearing on 8 January 2016 and remained on her caseload until 14 July 2016. It further noted that Miss Dearing completed a Galatean Risk and Safety Technology (GRiST) assessment for Patient U on 23 January 2016.

The panel considered that Witness 1 was unclear in her oral evidence when asked if a Risk and Relapse Form was also required for Patient U, in addition to the GRiST assessment form and she stated that she did not remember.

Therefore, although the panel found no documentary evidence of a Risk and Relapse Form completed by Miss Dearing, it found insufficient evidence that this was required at the relevant time.

In these circumstances, the panel found this charge not proved.

Patient W

This charge is found proved.

The panel noted that Patient W was allocated to Miss Dearing on 3 March 2016, remained on her caseload until 26 June 2016, and was later reallocated back to Miss Dearing on 24 November 2016. It further noted that Miss Dearing completed a GRiST assessment for Patient W on 2 March 2016.

The panel considered that Witness 1 stated in her oral evidence that a Risk and Relapse Form was also required for Patient W due to medication changes.

The panel found no documentary evidence of a Risk and Relapse Form completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave from 22 April 2016 to 12 May 2016. However, the panel was of the view that it was reasonable to expect that a Risk and Relapse Form should have been completed following the patient's allocation on 3 March 2016, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no Risk and Relapse Form was completed for Patient W.

Accordingly, this charge is found proved.

Patient Z

This charge is found NOT proved.

The panel noted that Patient Z was allocated to Miss Dearing on 21 January 2016 and remained on her caseload until 2 August 2016. It further noted that Miss Dearing completed a GRiST assessment for Patient Z on 23 January 2016.

The panel considered that Miss Dearing also completed a Community Clinical Risk Assessment Review document for Patient Z on 15 June 2016, in which she indicated that she had also completed a Risk Management and Enablement Plan.

Therefore, although the panel found no documentary evidence of a Risk Management and Enablement Plan or of a Risk and Relapse Form completed by Miss Dearing, it found insufficient evidence that either was required at the relevant time.

In these circumstances, the panel found this charge not proved.

Patient AA

This charge is found proved.

The panel noted that Patient AA was allocated to Miss Dearing on 7 June 2016 and remained on her caseload until 2 August 2016. It further noted that a GP letter was completed on 26 June 2016 with a paragraph on the patient's presentation and risks, which indicates that a Risk and Relapse Form would be required.

The panel found no documentary evidence of a Risk and Relapse completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 5 July 2016 to 31 August 2016. However, the panel was of the view that it was reasonable to expect that a Risk and Relapse should have been completed following the patient's allocation on 7 June

2016, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no care plan was completed for Patient AA.

Accordingly, this charge is found proved.

Patient BB

This charge is found proved.

The panel noted that Patient BB was allocated to Miss Dearing on 13 April 2015, remained on her caseload until May 2016. It further noted that Miss Dearing completed a GRiST assessment for Patient BB on 25 June 2015.

The panel considered that Witness 1 stated in her oral evidence that a Risk and Relapse Form was also required for Patient BB.

The panel found no documentary evidence of a Risk and Relapse Form completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave from 22 April 2016 to 12 May 2016. However, the panel was of the view that it was reasonable to expect that a Risk and Relapse Form should have been completed following the patient's allocation on 13 April 2015, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no Risk and Relapse Form was completed for Patient BB.

Accordingly, this charge is found proved.

Charge 9

9. Did not complete a Falls Risk Assessment in a timely manner, or at all, for Patient A

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Trust's Essential Elements of Defensible Documentation Policy and the patient records for Patient A.

The panel took into account its reasoning in Charge 3 for its interpretation of a timely manner in this context.

The panel noted that Patient A was allocated to Miss Dearing on 5 October 2017 and remained on her caseload until 1 May 2018. It further noted that Miss Dearing completed a Mental Health Physiotherapy Referral Form, dated 30 April 2018, in which she stated that there was a risk of falls for Patient A.

The panel considered that Witness 1 stated in her oral evidence that there should be additional information in a Falls Risk Assessment. As a result, the panel did not regard the Mental Health Physiotherapy Referral Form as a Falls Risk Assessment as this did not contain a complete assessment of the risk of falls identified.

The panel found no other documentary evidence of a Falls Risk Assessment completed by Miss Dearing.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a Falls Risk Assessment should have been completed following the patient's allocation on 5 October 2017, in a timely manner before the date Miss Dearing went on sick leave. The panel determined that no Falls Risk Assessment was completed for Patient A.

Accordingly, the panel found charge 9 proved.

Charge 10

10. Did not ensure notes were scanned on to ‘Lorenzo’ in a timely manner, or at all, for one or more of the patients set out in Schedule 6

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Trust’s Essential Elements of Defensible Documentation Policy and the patient records for each patient set out in Schedule 6.

The panel took into account its reasoning in Charge 3 for its interpretation of a timely manner in this context.

The panel had regard to Witness 1’s evidence in her written witness statement, in which she stated the following:

> ‘*Within the Team we use a program called Lorenzo. This is a computer system in which patient notes are kept.*
>
> *Before November 2017 we completed paper notes, which were then provided to our administrative team and uploaded to Lorenzo. The paper records were kept alongside the electronic copy and so there should have been two places that the patient records were kept. Before November 2017 Lorenzo was mainly used a supervision tool, as staff recorded who they saw and their travel time among other things. Records were mainly relied upon in hard copy at this time. However, staff were still required at this time to ensure all key documents were scanned to Lorenzo in order that key documents could be accessed easily.’*

The panel had regard to **Schedule 6**, which included the following two patients:

- Patient L
- Patient O

The panel considered the patient records for each patient separately.

Patient L

This charge is found NOT proved.

The panel could not find any convincing evidence of an allocation to Miss Dearing prior to 14 September 2017, although it noted that Miss Dearing had apparently completed an initial mental health assessment document on 3 May 2017.

The panel considered that the Mental Health Assessment Paperwork Administration Record stated that the initial mental health assessment was received on 4 May 2017 and uploaded on Lorenzo on 9 May 2017.

The panel acknowledged that Patient L's records included repeated visits undertaken by Miss Dearing, which were not transferred to Lorenzo. However, the panel considered that the notes regarding Patient L took place before November 2017, in which Witness 1 stated that prior to this period records were mainly relied upon in hard copy.

The panel therefore concluded that as Miss Dearing recorded notes in respect of Patient L prior to November 2017, it was not satisfied that this was Miss Dearing's duty at this time.

Accordingly, this charge is found not proved.

Patient O

This charge is found NOT proved.

The panel noted that Patient O was allocated to Miss Dearing on 18 August 2017.

The panel found that various notes recorded by Miss Dearing were not transferred onto Lorenzo prior to November 2017 for Patient O.

However, the panel considered that the notes regarding Patient O were made before November 2017, and that Witness 1 stated that prior to this period records were mainly relied upon in hard copy.

The panel concluded that as Miss Dearing recorded notes in respect of Patient O prior to November 2017, it was not satisfied that it was Miss Dearing's duty at this time to scan the record onto Lorenzo.

Accordingly, this charge is found not proved.

Charge 11

11. Did not complete a section '117 review' in a timely manner, or at all, for Patient B

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and 2. It also considered the documentary evidence exhibited, which included the Trust's Essential Elements of Defensible Documentation Policy and the patient records for Patient B.

The panel took into account its reasoning in Charge 3 for its interpretation of a timely manner in this context.

The panel noted that Patient B was allocated to Miss Dearing on 18 August 2017, remained on her caseload until November 2017, and was then later reallocated back to Miss Dearing from 18 March 2018 to May 2018 due to periods of sick leave. It further noted that Witness 2 completed a Working Age Adult and Older People Mental Health

Community Clinical Risk Assessment Review on 7 February 2017, which states that a Section 117 review takes place every six months '*as per trust guidelines'*.

The panel found that the only documentary evidence of a 117 review for Patient B completed by Miss Dearing was recorded to have taken place on 5 April 2018.

The panel took into account that Miss Dearing went on sick leave on 9 November 2017 to 2 February 2018. However, the panel was of the view that it was reasonable to expect that a 117 review should have been completed by Miss Dearing within six months after the last review on 7 February 2017. The panel therefore determined that the 117 review was not completed in a timely manner for Patient B.

Accordingly, the panel found charge 11 proved.

Charge 12

12. Did not complete paperwork relating to the initial assessment of Patient J in a timely manner, or at all

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the Trust's Essential Elements of Defensible Documentation Policy and the patient records for Patient J.

The panel took into account its reasoning in Charge 3 for its interpretation of a timely manner in this context.

The panel noted that Patient J was allocated to Miss Dearing on 21 June 2016, and Miss Dearing visited Patient J for an initial mental health assessment on 24 June 2016.

However, the panel found that Miss Dearing did not complete paperwork relating to the initial mental health assessment of Patient J prior to her sick leave on 5 July 2016.

The panel was of the view that it is reasonable to expect that paperwork for Patient J should have been completed by Miss Dearing within the ten working days following the initial mental health assessment, in a timely manner before the date Miss Dearing went on sick leave.

Accordingly, the panel found charge 12 proved.

Charge 13

13. Did not complete all required documentation in relation to a visit you made to Patient L on 24 October 2017

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the patient records for Patient L.

The panel noted that Patient L was allocated to Miss Dearing, at the latest, by 14 September 2017 and remained on her caseload until her sick leave on 9 November 2017. It further noted that Miss Dearing completed an initial mental health assessment on 18 September 2017, according to Witness 1.

The panel considered that in a Communication/Care Plan Evaluation Sheet dated 20 October 2017, concerns were raised about Patient L regarding significant risk factors relating to the patient absconding. In the Communication/Care Plan Evaluation Sheet dated 20 October 2017, it is noted that Miss Dearing agreed to visit the patient on 24 October 2017.

The panel further considered that in Witness 1's oral evidence, she explained that a risk assessment should have been completed for Patient L after Miss Dearing's visit, due to the concerns raised.

The panel found no documentary evidence of a risk assessment completed by Miss Dearing. The panel therefore determined that Miss Dearing did not complete all required documentation in relation to the visit made to Patient L on 24 October 2017.

Accordingly, the panel found charge 13 proved.

Charge 14

14. Did not visit one or more of the patients listed in Schedule 7 in a timely manner

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 4. It also considered the documentary evidence exhibited, which included the patient records for each patient set out in Schedule 7.

The panel had regard to **Schedule 7**, which included the following twelve patients:

- Patient K
- Patient M
- Patient P
- Patient Q
- Patient R
- Patient T
- Patient U
- Patient V
- Patient W
- Patient X

- Patient Z
- Patient AA

The panel considered the patient records for each patient separately.

Patient K

This charge is found NOT proved.

The panel noted that Patient K was allocated to Miss Dearing on 26 January 2016 and remained on her caseload until 22 February 2016. It further noted that Miss Dearing completed an initial mental health assessment for Patient K on 22 February 2016, which indicated that the patient was admitted to York Hospital in January 2016.

The panel found no documentary evidence to indicate when Patient K was discharged from York Hospital.

The panel considered that Witness 1 stated in her oral evidence that CPN's would not visit a patient who was admitted to Hospital.

Although the panel noted there was no evidence that Miss Dearing visited Patient K, it found that there was insufficient evidence to suggest this was required of Miss Dearing at the relevant time.

In these circumstances, the panel found this charge not proved.

Patient M

This charge is found proved.

The panel noted that Patient M was originally allocated to Miss Dearing in October 2016 and remained on her caseload until May 2018.

The panel considered that the evidence of Witness 1 and Witness 4, both provided detailed accounts indicating that Miss Dearing did not visit Patient M for a long period of time. Witness 1 indicated in her written witness statement that Miss Dearing did not visit Patient M between 13 October 2017 and 3 May 2018, in which she stated the following:

> *'so the patient went five months without being seen face to face by Ms Dearing.'*

The panel bore in mind that Witness 1 in her oral evidence indicated that a visit in this circumstance was warranted as the patient had several treatment changes and continued to deteriorate, which is evident in Patient M's records. Therefore, the panel was of the view that Miss Dearing did not visit Patient M in a timely manner.

Accordingly, this charge is found proved.

Patient P

This charge is found proved.

The panel noted that Patient P was allocated to Miss Dearing on 8 November 2016 and remained on her caseload until May 2018. It further noted that Miss Dearing completed an initial mental health assessment on 17 November 2016.

The panel found that Miss Dearing's earliest visit to Patient P was March 2017. The panel considered various risk factors in Patient P's records, which indicated a high-risk patient. Therefore, panel was of the view that Miss Dearing did not visit Patient P in a timely manner.

Accordingly, this charge is found proved.

Patient Q

This charge is found proved.

The panel noted that Patient Q was allocated to Miss Dearing on 7 March 2017, and Miss Dearing visited Patient Q on 14 March 2017. It further noted that Miss Dearing completed a GP letter, dated 28 March 2017, which states:

'*Plan is to visit weekly to monitor and review.*'

The panel found that Miss Dearing only visited Patient Q once after the date of the GP letter, namely on 25 April 2017. The panel determined that Miss Dearing's visit was not consistent with the plan indicated in the GP letter, dated 28 March 2017.

Therefore, panel was of the view that Miss Dearing did not visit Patient Q in a timely manner.

Accordingly, this charge is found proved.

Patient R

This charge is found proved.

The panel noted that Patient R was allocated to Miss Dearing on 2 December 2016, and first visited Patient R on 5 January 2017.

The panel considered risk factors in Patient R's records, which indicated increasing irritability and outbursts of aggressive behaviour. In Witness 1's written witness statement she identifies the following risk:

'*Patient R has Dementia with frontal lobe involvement, vascular origins and associated significant behavioural and psychological symptoms of dementia.'*

Therefore, panel was of the view that Miss Dearing did not visit Patient R in a timely manner.

Accordingly, this charge is found proved.

Patient T

This charge is found proved.

The panel noted that Patient T was allocated to Miss Dearing on 22 January 2016 and first visited Patient T on 4 February 2016.

The panel considered risk factors in Patient T's records, which indicated that the patient was difficult to engage. The panel considered that there was little evidence of serious attempts at engagement.

Therefore, the panel was of the view that Miss Dearing did not visit Patient T in a timely manner.

Accordingly, this charge is found proved.

Patient U

This charge is found proved.

The panel noted that Patient U was allocated to Miss Dearing on 8 January 2016 and first visited Patient U on 21 January 2016. It further noted that Miss Dearing completed a GP letter, dated 15 February 2016, which states:

> '*Michaella CPN and Sarah TSW to visit 2-4 weekly to review and continue to monitor thoughts of suicide / self harm with Patient U.*'

The panel found that Miss Dearing only visited Patient U only once after the date of the GP letter. The panel determined that Miss Dearing's visit was not consistent with the plan indicated in the GP letter, dated 15 February 2016.

Therefore, the panel was of the view that Miss Dearing did not visit Patient U in a timely manner.

Accordingly, this charge is found proved.

Patient V

This charge is found proved.

The panel noted that Patient V was allocated to Miss Dearing on 16 January 2016 and first visited Patient V on 3 March 2016.

The panel considered risk factors in Patient V's records. In Witness 1's written witness statement she identifies the following risk:

> '*Patient V has Dementia…'*

Therefore, the panel was of the view that Miss Dearing did not visit Patient V in a timely manner.

Accordingly, this charge is found proved.

Patient Z

This charge is found proved.

The panel noted that Patient Z was allocated to Miss Dearing on 21 January 2016 and visited Patient Z on the same day.

The panel considered Witness 1's written witness statement in which she stated that Miss Dearing did not visit Patient Z again until 15 June 2016:

> '*Ms Dearing did not visit Patient Z again until after 15 June 2016. During this time the Support Worker*, [Witness 5] *provided all support to Patient Z.'*

The panel considered that this is supported by Patient Z's records, which indicated nine visits from Witness 5 a TSW, between 30 March 2016 and 31 May 2016.

Therefore, the panel was of the view that Miss Dearing did not visit Patient Z in a timely manner.

Accordingly, this charge is found proved

Patient AA

This charge is found NOT proved.

The panel noted that Patient AA was allocated to Miss Dearing on 7 June 2016 and visited Patient AA on 8 June 2016. It further noted that Miss Dearing visited Patient AA again on 27 June 2016, before the patient was reallocated on 5 July 2016 due to her sick leave.

The panel determined that Miss Dearing visited Patient AA in a timely manner while the patient was on her caseload.

Accordingly, this charge is found not proved.

Charge 15

15. Did not take appropriate safeguarding steps in relation to one or more of the patients listed in Schedule 8

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 5 and Witness 6. It also considered the documentary evidence exhibited, which included the Trust's Safeguarding Adults Policy and Procedures and the patient records for each patient set out in Schedule 8.

The panel had regard to **Schedule 8**, which included the following two patients:

- Patient Y
- Patient Z

Patient Y

This charge is found NOT proved.

The panel noted that Patient Y was allocated to Miss Dearing on 14 February 2017 and remained on her caseload until May 2018.

The panel noted a Team Meeting Record dated 7 June 2017, which features notes from Miss Dearing in relation to safeguarding concerns for Patient Y. It further noted that a referral was made to the Trust's safeguarding team who later discharged the patient on 16 June 2016 and closed the referral.

The panel found that there was insufficient evidence in the documentation provided to suggest that Miss Dearing did not take appropriate safeguarding steps in relation to Patient Y.

In these circumstances, the panel found this charge not proved.

Patient Z

This charge is found proved.

The panel noted that Patient Z was allocated to Miss Dearing on 21 January 2016 and remained on her caseload until 2 August 2016.

The panel considered that the evidence of Witness 1, Witness 5 and Witness 6, were consistent in indicating that Patient Z had safeguarding concerns linked to bruising on the upper arms and carer stress, which required a visit.

The panel considered that Witness 5 states the following in her written witness statement:

> ‘*On or shortly after 24 May 2016 (I cannot recall exact date this conversation took place on), I told Miss Dearing that we needed to look at what support could be offered to Patient Z and her family and I explained that I was concerned that this could be a potential safeguarding issue. I asked Ms Dearing to visit Patient Z and to assess the situation. I cannot recall what Ms Dearing said to me in response to this. This conversation took place back at the office at the Trust. This was normal conversation to have after a visit as it would be usual for a TSW to speak to the CPN after a visit if they had any concerns.*

On 31 May 2016 I conducted another visit with Patient Z. Ms Dearing had still had not visited Patient Z at the time of the visit/ I had a conversation with Ms Dearing at some point after this visit (I cannot recall exactly when) and I asked Ms Dearing again to conduct a visit and assessment of Patient Z.

On 7 June 2016 Ms Dearing and I conducted a joint visit. Ms Dearing planned to visit Patient Z every four to six weeks. Ms Dearing made a referral to [Witness 6] (Band 6 Occupational Therapist) after the joint visit.'

The panel determined that it was not timely or appropriate for Miss Dearing's visit to take place two weeks after safeguarding concerns were raised on 24 May 2016.

Accordingly, this charge is found proved.

Charge 16

16. Did not ensure that one or more of the following were arranged/completed in respect of Patient Y

In reaching this decision, the panel considered the documentary evidence exhibited, which included the patient records for Patient Y.

The panel noted that Patient Y was allocated to Miss Dearing on 14 February 2017 and remained on her caseload until May 2018.

a. <u>Mental Capacity Assessment</u>

This charge is found proved.

The panel found no documentary evidence of a Mental Capacity Assessment completed by Miss Dearing while the patient was in her caseload. The panel determined that no Mental Capacity Assessment was completed for Patient Y.

Accordingly, this charge is found proved.

b. Addenbrooks Test

This charge is found proved.

The panel found no documentary evidence of an Addenbrooks Test completed by Miss Dearing while the patient was in her caseload. The panel determined that no Addenbrooks Test was completed for Patient Y.

Accordingly, this charge is found proved.

c. Referral to Physiotherapy or Occupational Therapy

This charge is found proved.

The panel found no documentary evidence of a referral to Physiotherapy or Occupational Therapy by Miss Dearing while the patient was in her caseload. The panel determined that no referral to Physiotherapy or Occupational Therapy was completed for Patient Y.

Accordingly, this charge is found proved.

d. Best Interest Meeting

This charge is found proved.

The panel noted that Miss Dearing had a discussion with MDT regarding Patient Y, however it found no documentary evidence of any action following this discussion on 1 August 2017 and no Best Interest Meeting while the patient was on her caseload.

The panel determined that Miss Dearing did not arrange a Best Interest Meeting for Patient Y.

Accordingly, this charge is found proved.

Charge 17

17 Carried out 'Transactional Analysis' with Patient AA when you were not qualified to do so

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1. It also considered the documentary evidence exhibited, which included the patient records for Patient AA.

The panel noted that Witness 1 stated the following in her written witness statement:

> *'Within Patient AA's communication sheets it states that Ms Dearing carried out Transactional Analysis with no supervision, which she is not qualified to do so. Transactional Analysis is something that is completed by a psychologist.*'

However, the panel found no documentary evidence to indicate that Miss Dearing carried out Transactional Analysis.

The panel considered that when questioned, in her oral evidence, Witness 1 was not able to set out what it was that indicated that Miss Dearing carried out Transactional Analysis.

In these circumstances, the panel found this charge not 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 Miss Dearing's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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

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

Mr Hoskins referred to the cases of *Roylance v General Medical Council, General Medical Council v Meadow* [2007] QB 462 and *Nandi v GMC* [2004] EWHC 2317 (Admin).

Mr Hoskins submitted that the facts found proved in the circumstances operated by Miss Dearing between 2016 - 2018 constitute a significant departure from the standards expected of a nurse. He submitted that Miss Dearing's actions had the potential to cause serious harm to patients and colleagues, and this was not significantly mitigated or justified by [PIRVATE] or situational factors such as the team environment/workload. He submitted that Miss Dearing's conduct would be deemed deplorable by fellow practitioners and amount to misconduct.

Mr Hoskins stated that the nature of the misconduct encompassed within the charges were errors fundamental to the care of patients. He submitted that the panel must have regard to the wider seriousness of the record keeping breaches and errors which were consistently repeated. He submitted that the types of errors were not, however, limited to record keeping. He submitted that the errors ranged from the delegation and treatment of more junior members of staff (Charge 1) and colleagues (Charge 2), to Miss Dearing's visits with her patients (Charge 14).

Mr Hoskins referred to the context of the facts found proved. He submitted that this involved patients who had a vulnerable profile, being of senior age and vulnerable in the context of illnesses which can change and progress at significant speed. He submitted that the situation of these patients is also relevant in that some were being cared for by loved ones rather than, generally, in an in-patient or care home environment. He indicated that in this way, failures in care which impact negatively on the patients invariably also impact negatively on the obligations placed on their loved ones.

Mr Hoskins also referred to the knowledge and experience of the witnesses who worked with Miss Dearing, in which they generally indicate that Miss Dearing's errors were of a very serious nature. He submitted that the witnesses were consistent, that underlying the charges, is an attitudinal issue.

Mr Hoskins highlighted management efforts to improve the quality of Miss Dearing's practise, which included supervision and adjustments to her work. He submitted that in relation to Miss Dearing's circumstances in the facts found proved, there was ample support, supervision and reasonable adjustments made to facilitate good practise in both the Goole and the Holderness team. He submitted that Miss Dearing demonstrated an attitudinal objection to management efforts.

Mr Hoskins identified the specific, relevant standards where Miss Dearing's actions amounted to misconduct.

Submissions on impairment

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

Mr Hoskins submitted that the basis of Miss Dearing's misconduct provides ample evidence to find that at the time of the misconduct (i.e. in the past), she breached the first three limbs of the test in *CHRE v NMC and Grant*. In terms of the future risk, he invited the panel to have regard to insight, irremediability, any remediation and risk of future repetition.

Mr Hoskins submitted that Miss Dearing has demonstrated almost no insight in relation to the facts found proved. He highlighted that Witness 1 and Witness 2 described Miss Dearing as actively avoiding or decreasing the levels of supervision deemed necessary. He also referred to Witness 7's evidence in which she stated that when Miss Dearing was challenged about her shortcomings in the Holderness team, her response was '*blazé'* and deflective. In addition, he submitted that in response to the NMC, in the early stages of this case, Miss Dearing again chose to make attacks, by unfounded allegations of bullying, on others rather than engage in reflection of her own practise.

Mr Hoskins submitted that in terms of irremediability, the NMC's position is that the underlying issue behind the misconduct is not that there were situational factors or particular features at that time that explain Miss Dearing's misconduct, but rather her shortcomings were her choice. He stated that this is outlined in the submissions on misconduct. He submitted that, as such, this case can properly be regarded as one involving a deep-seated attitudinal problem on the part of Miss Dearing, which is likely to be extremely difficult to remedy, notwithstanding no previous referrals or disciplinary findings and the positive references previously referred to.

In terms of evidence of remediation, Mr Hoskins submitted that the best and most recent evidence available is an email Miss Dearing sent to the NMC, dated 8 September 2021, in which she stated the following:

> '*I have not been practising since this process started and have no intention of ever returning to practise again and therefore seek to request removal from register'.*

Mr Hoskins submitted that, in light of the above, there is no evidence that the same fundamental shortcomings will not be repeated in the future.

Mr Hoskins invited the panel to find Miss Dearing's fitness to practise impaired on both public protection and public interest grounds. He submitted that if a finding of impairment

was not made in this case, professional standards and public confidence in the profession would be undermined.

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

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 Miss Dearing's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Dearing's actions amounted to a breach of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *2.1 work in partnership with people to make sure you deliver care effectively*
>
> ***8 Work co-operatively***
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *8.2 maintain effective communication with colleagues*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
> *8.4 work with colleagues to evaluate the quality of your work and that of the team*

8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice
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

11 Be accountable for your decisions to delegate tasks and duties to other people
11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

13 Recognise and work within the limits of your competence
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
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

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

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

20 Uphold the reputation of your profession at all times

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

24 Respond to any complaints made against you professionally

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges collectively and the circumstances of the case as a whole. It took account of all the evidence before it.

The panel had regard to the facts found proved and determined that Miss Dearing's actions demonstrated failings in basic fundamental elements of nursing. The panel was of the view that as an experienced nurse, the range and nature of the documentation errors/omissions, alongside other failures such as: not undertaking appropriate safeguarding steps, lack of attendance at supervision sessions, and lack of support for TSWs, demonstrated an unacceptably low standard of professional practice. The panel

found that Miss Dearing's actions exposed numerous vulnerable patients to serious risk of harm and also impacted on the follow up care patients received from other professionals.

The panel also had regard to context, such as alleged bullying, [PRIVATE]. However, the panel noted that Miss Dearing was given the opportunity to change locations, had her caseload significantly reduced, and was offered extensive support and assistance from the Trust in relation to her performance. Miss Dearing was also provided with regular supervision and given traveling time when she moved to the new team as this was further from her home. The panel considered that despite the various measures of support offered by the Trust, Miss Dearing did not make any sustained improvements to the standard of her practice. Indeed, the panel noted that, after being given a fresh start in a new team, Miss Dearing's same pattern of not completing adequate paperwork began immediately and she was informed of the issues within her first week. Miss Dearing was also given an opportunity to work from home to catch up on overdue paperwork and this did not yield the anticipated results.

The panel also considered that the facts found proved do not relate to an isolated incident, rather that they collectively demonstrate a pattern of behaviour over a prolonged period of time that fails to acknowledge professional and clinical protocols, and led to unsafe practice.

The panel was in no doubt that Miss Dearing's actions found proved collectively amounted to serious misconduct, given their nature, duration and context. The panel was of the view that the variety and combination of Miss Dearing's actions in the charges found proved were indicative of deep-seated attitudinal problems. The panel determined that Miss Dearing's actions would be considered deplorable by fellow practitioners, thereby damaging the trust that the public places in the profession.

The panel therefore concluded Miss Dearing's actions did fall seriously short of the conduct and standards expected of a Band 5 CPN and amounted to misconduct.

Decision and reasons on impairment

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

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

The panel determined that limbs a, b and c in the above test were engaged in this case.

Taking into account all of the evidence adduced in this case, the panel found that patients were put at risk of serious harm as a result of Miss Dearing's misconduct. The panel was of the view that Miss Dearing's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel next went on to consider the matter of insight. It took into account Miss Dearing's response to the regulatory concerns. The panel found that Miss Dearing's response to the NMC did not address all the concerns about her practice. It also found that where Miss Dearing did reflect on some of the concerns raised, there were notable attempts to deflect blame and responsibility. The panel was of the view that Miss Dearing has not demonstrated any understanding of how her actions put patients at a risk of serious harm or how this impacted negatively on her fellow team members and the reputation of the nursing profession. The panel determined that Miss Dearing demonstrated a significant lack of insight and remorse.

The panel determined that the misconduct in this case is attitudinal and therefore more difficult to remediate. The panel carefully considered the evidence before it in determining whether or not Miss Dearing has taken steps to strengthen her practice. However, the panel has not received any information to suggest that Miss Dearing has taken steps to address the specific concerns raised about her practice, such as relevant training. The

panel bore in mind that Miss Dearing does not appear to have worked in a clinical setting since the referral.

The panel was of the view that there is a high risk of repetition based on the lack of evidence of insight, remorse, and no evidence that Miss Dearing has strengthened her practice. The panel considered that Miss Dearing's actions set out in the charges found proved demonstrated a pattern of behaviour that fails to acknowledge professional and clinical protocols, which inevitably led to unsafe practice. It took into account the fact that the concerns were repeated, even after Miss Dearing had moved to a different team within the Trust. On the basis of all the information before it, the panel decided that there is a risk to the public if Miss Dearing was allowed to practise without restriction. The panel therefore determined that a finding of current impairment on public protection grounds is necessary.

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

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

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

Sanction

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

Mr Hoskins informed the panel that in the Notice of Hearing, dated 1 August 2022, the NMC had originally advised Miss Dearing that it would seek the imposition of a suspension order for a period of six months, with review, if it found Miss Dearing's fitness to practise currently impaired.

However, during the course of the hearing, the NMC revised its proposal to a striking-off order. Mr Hoskins submitted that a striking-off order is more appropriate in light of the evidence arising from the witnesses in this case, which indicated underlying deep-seated attitudinal problems. He submitted that given the scale of the misconduct, the lack of insight over a prolonged period of time, deep-seated attitudinal problems and Miss Dearing's recent request to be removed from the NMC register, a striking-off order would be proportionate.

Mr Hoskins outlined aggravating factors in this case, which he identified as:

- Fundamental failings characterised by Miss Dearing's unwillingness to fulfil her responsibilities, and her unpredictable practice which resulted from this;
- Lack of insight;
- Conduct which put patients at risk of harm;

- Conduct which has had an impact on the work of colleagues; and
- The fact that Miss Dearing was given the opportunity to change teams and the issues persisted.

Mr Hoskins also outlined mitigating factors in this case, which he identified as:

- No previous disciplinary findings;
- Long standing unblemished career prior to the referral;
- Described as a talented practitioner by a colleague;
- No patient harm;
- [PRIVATE]; and
- Bullying allegation, although unfounded in this case, could be considered to have had an impact based on Miss Dearing's subjective perspective.

Mr Hoskins submitted that making no order or imposing a caution order would not be appropriate in this case given the seriousness of the misconduct and the ongoing risk of harm to patients.

Mr Hoskins submitted that a conditions of practice order would not be appropriate given the fact that Miss Dearing has already been subject to, in effect, conditions from the Trust, such as supervision and further training, and this has not resulted in any improvement in her practice. He submitted that the concerns in this case did not relate to Miss Dearing's skills as a nurse, but rather her unwillingness to fully undertake duties associated with her role.

Mr Hoskins further submitted that a suspension order would not be appropriate as there was more than a single instance of misconduct in this case, there is evidence of deep-seated attitudinal problems and there is also a lack of insight. He stated that although there has been no evidence of repetition since the referral, there is no evidence that Miss Dearing has been working as a nurse since.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct over a prolonged period of time, with multiple patients involved;
- Misconduct which continued even after Miss Dearing was moved to a different team within the Trust;
- Miss Dearing's unwillingness to fulfil her responsibilities, and her unpredictable practice which resulted from this;
- No insight;
- Conduct which put patients at risk of harm; and
- Conduct which has had an impact on the work of colleagues and repeatedly caused them to bear additional responsibility for tasks which Miss Dearing should have carried out herself.

The panel also took into account the following mitigating features:

- Described as clinically able by colleagues;
- No patient harm;
- [PRIVATE];
- No regulatory concerns in her career prior to referral; and
- Bullying allegation, although unfounded in this case, may have had an impact based on Miss Dearing's subjective perspective.

The panel had regard to contextual factors that may have had an impact on Miss Dearing's performance from her own subjective perspective, namely the bullying allegation. However, the panel determined that since the bullying allegation was unfounded, this was not a mitigating feature that justifies the repeated misconduct in this case.

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 not protect the public or satisfy public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Dearing's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Dearing's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified and would not be in the public interest.

The panel next considered whether placing conditions of practice on Miss Dearing's registration would be a sufficient and appropriate response. The panel considered that the concerns in this matter related to Miss Dearing demonstrating a pattern of behaviour that fails to acknowledge professional and clinical protocols, which is indicative of deep-seated attitudinal problems. The panel took into account that it did not receive any evidence of insight or remorse and was not aware if Miss Dearing would be willing to submit to and comply with conditions. The panel took the view that Miss Dearing had, in effect, already been subject to conditions imposed by her employer, namely extra supervision meetings and increased scrutiny but this had not resulted in an improvement in her performance. The panel therefore concluded that the placing of conditions on Miss Dearing's registration

would not adequately protect the public and meet the public interest, nor would it mark the gravity of the multiple failings in this case.

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

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

The panel considered that the concerns in this case do not relate to an isolated incident and found that there was a pattern of misconduct over a prolonged period. The panel was of the view that the repeated misconduct in this case reflected deep-seated attitudinal problems. It also found no insight or remorse, and a consequent risk of repetition.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Dearing's actions was fundamentally incompatible with Miss Dearing remaining on the register. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that the findings in this particular case demonstrate that Miss Dearing's actions were serious and to allow her to continue practising would put patients at risk of serious harm and undermine public confidence in the profession and in the NMC as a regulatory body.

The panel determined that Miss Dearing has not demonstrated any insight or remorse into her misconduct. Further, the panel considered that Miss Dearing has not demonstrated that she can be trusted, as a registered nurse, to act with care and keep patients safe from unwarranted risk harm. In addition, the panel has had no information to indicate that Miss Dearing has done anything to strengthen her practice. The panel was of the view that members of the public would be concerned if a registered nurse who breached professional and clinical protocols with such breadth and frequency as in the circumstances of this case, was allowed to remain on the register. Taking account of the SG, the panel could not be satisfied that anything less than a striking-off order would maintain professional standards, keep the public protected and address the public interest in Miss Dearing's case.

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

This will be confirmed to Miss Dearing in writing.

Submissions on interim order

The panel took account of the submissions made by Mr Hoskins. He submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. He invited the panel to impose an interim suspension order for a period of 18 months for the reasons stated in the panel's findings.

Interim order

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

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

Decision and reasons on interim order

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

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

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

That concludes this determination.