Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 11 September to Wednesday 20 September 2023

Virtual Hearing

Name of Registrant:	**Cosmin-Andrei Ivana**
NMC PIN	15L0363C
Part(s) of the register:	Registered Adult Nurse, Level 1 (December 2015)
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Nicholas Rosenfeld (Chair, Lay member) Helen Chrystal (Registrant member) Keith Murray (Lay member)
Legal Assessor:	Graeme Sampson
Hearings Coordinator:	Berivan Genc
Nursing and Midwifery Council:	Represented by Mary Ellen Stewart, Case Presenter
Mr Ivana:	Not present and not represented Present but not represented (13 September 2023)
Facts proved by admission:	1a, 2a, 2b, 2d, 4a, 4c, 5a, 5b, 5c
Facts proved:	1b, 2c, 4b and 6
Facts not proved:	2e, 2f and 3
Fitness to practise:	Impaired
Sanction:	**Conditions of Practice Order (12 months)**

Interim order:	**Interim Conditions of Practice Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Ivana was not in attendance and that the Notice of Hearing letter had been sent to Mr Ivana's registered email address by secure email on 7 August 2023.

Ms Stewart, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor and referred itself to the NMC's guidance document reference PRE-6 "*notice of our hearings and meetings*" last updated 14 October 2022.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Ivana right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Ivana 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 Mr Ivana – first application

The panel next considered whether it should proceed in the absence of Mr Ivana. It had regard to Rule 21 and heard the submissions of Ms Stewart who invited the panel to continue in the absence of Mr Ivana. She submitted that all reasonable efforts have been made to secure Mr Ivana's attendance to this hearing.

Ms Stewart referred the panel to the disclosure request made by the Royal College of Nursing ('RCN') on 9 August 2023, who were representing Mr Ivana at the time. The RCN made 6 requests for disclosure and the NMC had processed this disclosure request the day after it was made, asking the referrer for this additional documentation. This additional documentation was received by the NMC on Friday 8 September 2023 and has not been served on Mr Ivana. Ms Stewart submitted that there has been no request by Mr Ivana to adjourn the hearing pending this disclosure and there is no suggestion that the lack of disclosure is material to Mr Ivana's decision not to attend this hearing. Therefore, Ms Stewart invited the panel to proceed in Mr Ivana's absence and not speculate on reasons why he has not attended the hearing today. She also submitted that Mr Ivana has not informed the NMC with any reason regarding why he did not attend the hearing and there is no reason to suppose he would attend if the matter were to be postponed.

The panel accepted the advice of the legal assessor.

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

The panel has decided not to proceed in the absence of Mr Ivana at this stage. In reaching this decision, the panel has considered the submissions of Ms Stewart, and the advice of the legal assessor. It 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. The panel also referred itself to the NMC guidance CMT-8 '*proceeding with hearings when the nurse, midwife or nursing associate is absent*' last updated on 13 January 2023. It noted that:

- Given the nature of the allegations against Mr Ivana, it would be in the public interest in the expeditious disposal of the case to proceed in his absence.
- The panel accepted that there are witnesses waiting to give evidence, who would be inconvenienced should this matter not proceed.
- Mr Ivana has made it clear that he wishes to engage with the process as he confirmed in his email dated 7 September 2023, that he will be representing himself at the hearing after being informed that the RCN will no longer represent him. Though the panel were unaware of his reasons for his non-attendance.
- In relation to fairness to Mr Ivana, the panel determined that it would be unfair to proceed given that the disclosure documentation requested, had not been served on him to date. The panel suggested that this documentation be served on him via email at the earliest convenience with a 'read receipt' to confirm Mr Ivana has received the document. The panel determined that it is important for Mr Ivana to view this document and whether it would impact on his defence to these allegations.
- In view of the above, the panel determined that at this stage, it would not be fair, appropriate or proportionate to proceed in his absence at this point.

In these circumstances, the panel has decided not to proceed in the absence of Mr Ivana and has postponed this hearing until tomorrow at 10:00 to allow time for Mr Ivana and Ms Stewart to consider the additional disclosure documentation.

Decision and reasons on proceeding in the absence of Mr Ivana – second application

The panel considered whether it should proceed in the absence of Mr Ivana. It had regard to Rule 21 and heard the submissions of Ms Stewart who invited the panel to continue in the absence of Mr Ivana. She submitted that all reasonable efforts have been made to secure Mr Ivana's attendance to this hearing.

Ms Stewart submitted that Mr Ivana was sent a disclosure bundle via email with a 'read receipt' and was contacted on 11 September 2023 by email and telephone. Mr Ivana was contacted again during the morning on 12 September 2023 by email and telephone and there was no response from Mr Ivana. On that basis, Ms Stewart submitted that Mr Ivana had voluntarily absented himself and that the hearing should proceed in his absence as Mr Ivana has not provided any response or 'good reason' for his non-attendance. She further submitted that there is no reason to suppose Mr Ivana would attend if the matter were to be further postponed and therefore, invited the panel to proceed in Mr Ivana's absence.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Ivana. In reaching this decision, the panel has considered the submissions of Ms Stewart, and the advice of the legal assessor. It 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. The panel also referred itself to the NMC guidance CMT-8 '*proceeding with hearings when the nurse, midwife or nursing associate is absent*' last updated on 13 January 2023. It noted that:

- Given the nature and seriousness of the allegations against Mr Ivana, it would be in the public interest in the expeditious disposal of the case to proceed in his absence.
- Mr Ivana was contacted four times on 12 September 2023 and a number of times on 11 September 2023 regarding his attendance to the hearing. The panel noted that there were two emails sent to Mr Ivana one at 9:58 and

one at 10:30 followed by two phone calls. The panel was of the view that reasonable efforts were made.

- The panel accepted that there are witnesses waiting to give evidence, who would be inconvenienced should this matter not proceed.
- Mr Ivana has made it clear that he wishes to engage with the process as he confirmed in his email dated 7 September 2023, that he will be representing himself at the hearing after being informed that the RCN will no longer represent him. Though the panel were unaware of his reasons for his non-attendance.
- In relation to fairness to Mr Ivana, the panel determined that it would not be unfair to proceed given that the disclosure documentation requested, had now been served on him.
- In view of the above, the panel determined that at this stage, it would be fair, appropriate or proportionate to proceed in his absence.

In these circumstances, the panel has decided to proceed in the absence of Mr Ivana.

Details of charge

That you, a registered nurse:

1) On 24 April 2020 during the initial assessment in relation to Patient A, failed to:

   a) complete an accurate assessment of Patient A's wound;
   b) take baseline photographs of Patient A's wound;

2) Between 24 April 2020 and 10 May 2020, on more than one occasion, did not follow the correct procedure when providing wound care to Patient A by failing to:

   a) complete accurately or at all the wound care chart after changing the wound dressing;

b) record an accurate assessment of the condition of the wound;
c) measure the wound;
d) take photographs of the wound each time the wound dressing was changed;
e) change the wound dressing every 3 days as required to do so;
f) note the signs of infection in the care plan and/or escalate appropriately

3) Between 24 April 2020 and 10 May 2020 having been told by Patient A on more than one occasion that the wound may be infected, failed to take appropriate or/any action to escalate the deterioration in the condition and/or seek medical assistance in a timely manner;

4) Between 24 April 2020 and 10 May 2020, in relation to Patient A, failed to maintain an adequate level of record keeping in that you:

a) did not complete properly or at all the care records to provide an accurate reflection of the condition of the wound;
b) did not identify and/or note the changes in the condition of the wound;
c) continued to record that there were no concerns or changes to the condition of the wound;

5) On 15 May 2020 during a telephone conversation with Colleague A you provided Colleague A with an inaccurate description of the condition of Patient A's wound in that you said:

a) Patient A's wound was not infected;
b) there was a small wound with no discharge;
c) Patient A's wound dressing was being changed every 2 days when it was not;

6) On 25 May 2020 at a clinical concern meeting inaccurately reported that Patient A's wound was 'grade 2' and healing properly despite the wound being infected;

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

Background

At the time of the concerns raised in the referral, Mr Ivana was employed at Hamble Heights Care Home via an agency called Mploy. Mr Ivana covered a number of shifts at Great Oaks care home ('the Home'), which is the Home at which these alleged incidents occurred. It is alleged that on the 22 April 2020, Patient A, was admitted to that Home with a surgical wound and at the time of admission, the wound was healing and free from infection. It was expected the wound would be dressed every three days or more frequently if there were concerns of an infection.

Mr Ivana was one of the nurses who provided wound care to Patient A. The charges concerned your record keeping and failure to escalate the deterioration of the wound and your misleading communication regarding the progress of the wound healing process with a doctor external to the Home. It is alleged that Mr Ivana maintained that Patient A's wound was healing and that there were no signs of infection. The wound was observed to be infected on the 26 May 2020, when another nurse had changed the wound dressing. The matter was reported to safeguarding the same day and initial investigations of facts was carried out. Patient A's wound had deteriorated to such an extent that she was urgently admitted to the hospital requiring an above knee amputation. Following a local investigation, Mr Ivana was dismissed on the 27 May 2020.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Stewart on 13 September 2023 to amend the wording of charge 6.

The proposed amendment was to provide clarity and more accurately reflect the evidence. It was submitted that the proposed amendment would not cause prejudice to you.

That you, a registered nurse:

6. On 25 May 2020 at a clinical concern meeting **or shortly thereafter** inaccurately reported that Patient A's wound was 'grade 2' and healing properly despite the wound being infected;

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

Having joined the hearing for the first time on the morning of 13 September 2023, you made no objection to this amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). The panel also referred itself to the NMC Guidance reference PRE-2c how a charge becomes final, which was last updated on 23 June 2021.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Stewart under Rule 31 to allow the written statement of Patient A, Witness 2 and Witness 3 into evidence. Ms Stewart submitted that

the evidence of these three witnesses is highly relevant and that having them form part of the evidence before the panel is fair.

In connection with Patient A's evidence, Ms Stewart submitted that Patient A is deceased, but has provided a relevant and insightful witness statement to the NMC before she passed away. Ms Stewart submitted that Patient A provided direct evidence of the treatment she received from you and her evidence relates to a number of charges. Ms Stewart submitted that Patient A in her witness statement, would assist the panel in their determination regarding the facts in connection with proving the allegations.

With regard to Witness 2's evidence, Ms Stewart submitted that Witness 2 was a General Practitioner ('GP') on call when this matter was referred by the Home to the GP and accordingly, her evidence is also relevant. Ms Stewart submitted that Witness 2 in her witness statement gives evidence of the call she received from the Home to explain the wound had broken down and the photographs that were sent to her. Ms Stewart submitted that Witness 2 gives evidence of the conversations that she had with the surgeon regarding the next steps for Patient A. Ms Stewart submitted that it would be relevant and fair to admit this evidence as hearsay.

Lastly, in relation to the evidence of Witness 3, Ms Stewart submitted that this is relevant because she was a nurse who visited Patient A on 26 May 2020, she had noticed the wound was infected and instigated escalation procedures. Ms Stewart submitted that Witness 3 in her witness statement explained what she saw on that day when she dressed the wound and provided a vivid description of what she saw, but also stated that she had a conversation with the surgeon who had reviewed the photographs of the wound taken that day and confirmed his opinion that the wound was infected. Ms Stewart submitted that Witness 3's evidence is important in respect of a number of the charges and that admitting her evidence would be fair in all the circumstances. Therefore, Ms Stewart invited the panel to admit the evidence from three witnesses as hearsay on the basis that it would be both relevant and fair.

When the Chair had asked about what steps the NMC had taken in relation to the attendance of Witness 2 and 3, Ms Stewart submitted that this is not a determinative factor in the question of whether to admit evidence and that the question is one of fairness. That being so, she submitted that it is a factor to consider, but not determinative. Ms Stewart submitted that she was unable to assist the panel on whether the NMC had taken reasonable steps to secure the witnesses attendance.

You made no objections to the hearsay application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The panel also referred itself to the NMC Guidance 'evidence' to be found at DMA-6 last updated on 1 July 2022. In particular, the sub section on hearsay.

The panel was minded that the application should not be regarded as a routine matter and that they should consider the issue of fairness before admitting the evidence.

The panel considered whether you would be disadvantaged in acceding to the application by the NMC upon their reliance of the live testimony of Patient A, Witness 2 and Witness 3 to that of admitting their written statements as hearsay testimony into evidence. The panel borne in mind that with the admittance of this evidence, neither you nor the panel would have an opportunity to test it.

The panel determined that it would be fair to admit Patient A's written statement given that she had died. The panel acknowledged that this Patient is the subject of your alleged misconduct and that the allegations against you are serious in their nature. The panel was of the view that this Witness did not provide sole and decisive evidence and is corroborated with other evidence such as, Witness 1's evidence who confirmed that she had met with and spoken to Patient A before she was readmitted to the hospital. The

panel also acknowledged that there was other corroborative evidence before them. The panel determined that there is no suggestion that this evidence is fabricated. It noted though, this evidence could have an impact on your career, but there was a good reason for this Patient's non-attendance, which was incapable of rectification. Therefore, the panel allowed Patient A's statement to be admitted as hearsay and determined that it was clearly relevant and it would not be unfair for it to be admitted.

In relation to Witness 2, the panel determined that this is not the sole and decisive, evidence as it is corroborated by other evidence. The panel considered that there is no suggestion of fabrication and did go to the seriousness of the charges. The NMC offered no reason for the non-attendance of the Witness or the steps taken to secure attendance. It bore in mind that you had only been given notice of this hearsay application on 13 September 2023. The panel determined that due to the nature of the allegations, it would allow this evidence to be admitted as hearsay. It was of the view that this is corroborated by other evidence, you did not challenge the content of the statement, it went to the seriousness of the charges and therefore determined that it would be fair to admit this evidence as hearsay.

Lastly, in relation to Witness 3, the panel noted that there is no information as to the steps the NMC have taken to secure attendance of this witness nor the reason for the non-attendance. The panel considered this evidence to be relevant to the allegation as this witness was the one who changed the dressing of Patient A and escalated the condition of the wound on 26 May 2020.

The panel determined that this is not the sole and decisive evidence in support of the allegations as there is other evidence that corroborates this witness's evidence. The panel acknowledged that you did not challenge the content of this witness's statement and there is also no suggestion of fabrication. The panel found it unsatisfactory that the NMC had provided no explanation as to why this witness did not attend the hearing or what steps they had taken to secure the attendance. However, in determining the issue, the panel decided that it would be fair to admit the evidence given its relevance to the allegations.

In these circumstances, the panel reached to the view that it would be fair and relevant to accept into evidence the written statements of Patient A, Witness 2 and 3 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

When you attended the hearing on 13 September 2023 (day 3), the charges were put to you and you made admissions to the following charges 1a, 2a, 2b, 2d, 4a, 4c and 5a, 5b and 5c.

The panel therefore finds charges 1a, 2a, 2b, 2d, 4a, 4c and 5a, 5b and 5c proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Stewart and by you.

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

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

- Witness 1: Encores Care and Quality Director
- Colleague A: Consultant in Rehabilitation Medicine

The panel also read the statements of:

- Witness 2: General Practitioner
- Witness 3: Staff Nurse
- Patient A: Patient A

Though invited, and following advice from the legal assessor, you chose not to give evidence to the panel.

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

Charge 1b)

That you, a registered nurse, on 24 April 2020 during the initial assessment in relation to Patient A, failed to:

b) take baseline photographs of Patient A's wound.

This charge is found proved.

In reaching this decision, the panel considered the oral evidence of Witness 1 on 12 September 2023, where she confirmed that you had a duty to take baseline photographs of Patient A's wound. During the course of her evidence, which the panel found both credible, reliable and knowledgeable she referenced a wound care policy. The Witness

explained that the policy required baseline observations to be taken during initial assessment. She explained in her evidence that:

> *"Copies of all policies were in every nurses office and that would have been pointed out to him on induction."*

The panel also considered the Investigation Report produced by Witness 1, which confirms that no baseline photographs of the wound were taken. The panel determined that it is fundamental basic nursing care to take initial baseline photographs of a patient's wound and this should have been taken during the initial assessment on 24 April 2020.

The panel was satisfied that there was a policy and as a nurse, you would have known to take photographs, which in the panel's opinion, inferred the obligation.

The panel also considered the 'Wound Assessment, Care Plan and Dressing Record' form ('the Form') completed by you on 24 April 2020. This was the initial assessment. It states:

"*wound photography should be completed on assessment*" and "*all wounds must be photographed without exception.*"

The Form clearly states, "*attach photograph here.*" There was no photograph attached to the Form.

Therefore, the panel was satisfied that, you undertook the initial assessment on 24 April 2020, you had a duty to take baseline photographs of Patient A's wound and that no photograph was taken. The panel therefore finds on the balance of probabilities, this charge proved.

Charge 2c)

> "That you, a registered nurse, between 24 April 2020 and 10 May 2020, on more than one occasion, did not follow the correct procedure when providing wound care to Patient A by failing to:
>
> (c) measure the wound;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's oral evidence where she made reference to the wound care policy. She was very clear that there was a duty to measure the wound. There were paper tapes for measuring, so that it could be placed next to the wound for this very purpose. She intimated that this was basic wound care procedure. Based on the oral evidence of Witness 1, the policy document of the Home, combined with this being with basic wound care practice, the panel was satisfied that this inferred a further obligation on you.

Witness 1 in her investigation report also confirms that the wound should have been measured and recorded on the wound care plan or in the progress notes.

The panel also had regard to the Form, which also requires the wound to be measured. The documentary evidence confirmed that you had changed the dressing on 24, 25 and 29 April 2020 as well as 2, 5, 7 and 10 May 2020, and on each occasion, no measurements had been taken or recorded on those dates as per the obligation on you to do so.

The panel also considered the Patient A's written statement where she stated:

> *'I don't think he ever measured it'*.

The panel determined that the documentation corroborates that the wound was never measured as there were no measurements recorded. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 2e)

> That you, a registered nurse, between 24 April 2020 and 10 May 2020, on more than one occasion, did not follow the correct procedure when providing wound care to Patient A by failing to:
>
> e) change the wound dressing every 3 days as required to do so.

This charge is found NOT proved.

The panel had regard to the investigation report, the Form and the oral evidence provided by Witness 1 and determined that there was an obligation to change the dressing every three days (as stated in care plan form). The panel noted that the Form states that the wound dressing should be changed every three days and therefore, this was evidence from which it could infer an obligation. The evidence before the panel is that the wound dressing was changed by you on 24, 25, 28 and 29 April 2020 and 2, 5, 7 and 10 May 2020.

On the basis of the evidence before it, the panel determined that the wound dressing was changed within the frequency suggested in the care plan and therefore, on the balance of probabilities, found this charge not proved.

Charge 2f)

> That you, a registered nurse, between 24 April 2020 and 10 May 2020, on more than one occasion, did not follow the correct procedure when providing wound care to Patient A by failing to:

f) note the signs of infection in the care plan and/or escalate appropriately.

This charge is found NOT proved.

The panel was satisfied that you changed the wound on 24, 25, 28 and 29 April 2020 and 2, 5, 7 and 10 May 2020, but noted that there is no photograph of the wound attached to those records. Therefore, the panel determined that there was no direct evidence before it to indicate that the wound was infected between 24 April 2020 and 10 May 2020. If no evidence was adduced that the wound was infected between the dates of the charge, there was nothing to substantiate that there was anything to escalate. Indeed, when Colleague A gave evidence on 13 September 2023, in relation to a photograph of the wound, which postdated 10 May 2020, she stated:

"No evidence to show infection. It does not look infected."

Given the experience of Colleague A, who was a consultant in this field of some 20 years standing, the panel found her evidence to be both reliable and credible.

Based on the lack of evidence and on the balance of probabilities, the panel found this charge not proved.

Charge 3)

Between 24 April 2020 and 10 May 2020 having been told by Patient A on more than one occasion that the wound may be infected, failed to take appropriate or/any action to escalate the deterioration in the condition and/or seek medical assistance in a timely manner.

This charge is found NOT proved.

The panel considered Patient A's written statement where she stated:

> *'For about two and a half weeks, when Jack came to take the bandages off, the wound on my leg was turning more yellow and the smelling was getting worse. The holes in the stitches were also getting bigger. I said to him every time he changed it that the smell is getting to me. I also asked him if it was infected. Every time he would say no, I will just wipe it and redress it, there were no photographs taken. He didn't seemed bothered about it. I knew something wasn't right. I didn't raise this to anybody as I trusted him because he was the nurse and therefore he knew better.'*

The panel were satisfied that Patient A on more than one occasion, stated that the wound may be infected, but there was no evidence that the wound was actually infected between the dates of the charge. If there was no evidence that the wound was actually infected then it is not possible to determine whether he was required to escalate the deterioration or request for medical assistance in a timely manner. The panel therefore determined that there is no evidence between 24 April and 10 May 2020, that the wound was infected or how it had deteriorated during that specific timeframe. On the balance of probabilities, the panel found this charge not proved.

Charge 4b)

> Between 24 April 2020 and 10 May 2020, in relation to Patient A, failed to maintain an adequate level of record keeping in that you:
>
> b) did not identify and/or note the changes in the condition of the wound.

This charge is found proved.

The panel had regard to the 'record of dressing changes and assessment of wound' documentation completed by you through the period specified in the charges. The panel noted that these documents do not indicate that you have recorded any changes to the

wound. The panel did note that on occasion, your notes stated, "*no signs of infection*." However, the panel did not regard this to indicate whether there had been any changes in the condition of the wound.

Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 6)

> On 25 May 2020 at a clinical concern meeting, inaccurately reported that Patient A's wound was 'grade 2' and healing properly despite the wound being infected.

This charge is found proved.

The panel had regard to the statement taken from you on 27 May 2020. The panel noted from that document that during the course of the Weekly Resident Concern meeting on 25 May 2020, you had told the clinical lead that the wound was '*grade 2 and healing well'* though you thought you described it as grade 3 and that this description was documented by the clinical lead.

The panel considered the records of the Weekly Clinical Meeting and noted that there is no record of the grading of the condition of the wound or whether it was healing well.

Witness 1 in her oral evidence, stated that if you had mentioned the grading of the wound during the course of that meeting, the manager would have made note of it. She stated that "*my belief is that he did not mention it*."

The panel also considered the investigation report where it states:

> *'He was asked about his report at the weekly clinical concerns meeting on 25th when he had said the wound was a grade 2 and healing, he though he has said grade 3 but was informed it was recorded by witnesses as grade 2. He was*

shocked when presented with the photographs of stump and said when he dressed it 3 days ago (23/5/2020) it was not like this.'

There was some lack of clarity as to when the comments which were the subject of the charge were made. Whether they were made at the meeting or shortly thereafter, the panel was satisfied that you did make these comments and that they were inaccurate.

The panel had regard to Witness 3's written statement where she stated:

'I started to undress the dressing on the wound to see what was going on. Once I saw the open wound, I realised that it wasn't right and everything was infected. The wound was yellow and green which is a big sign of an infection. On the side it was black which necrotic. I told her 'look I think your wound is infected, I want someone else to see'. I never saw such an infected wound in my life.'

The panel noted that Witness 3 had examined the wound on 26 May 2020, which was the day after the clinical meeting. The panel inferred that it was likely to have been infected on 25 May 2020 and there is a reference in the clinical meeting that you had reported Patient A's wound was a '*grade 2 and healing properly'* despite the wound had been infected on 25 May 2020. On the balance of probabilities, the panel found this charge proved.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Ms Stewart 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.

Ms Stewart identified the specific, relevant standards where your actions amounted to misconduct. *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* Ms Stewart identified the following sections of the Code which has been breached:

> ***6 Always practise in line with the best available evidence***
>
> ***8 Work cooperatively***
> *8.1 respect the skills, expertise and contributions of your colleagues, refer 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.*
>
> ***10 Keep clear and accurate records relevant to your practice***

In relation to charge 1a and 1b, Ms Stewart submitted that you had a duty to complete an accurate assessment of a patient's wound, to take baseline photographs and to do both of these things at the point of admission. She submitted that these duties derive from the duty to practise effectively and to accurately keep records as set out in the Code, in particular, to section 10 of the Code as listed above. Ms Stewart submitted that your failure to complete an accurate assessment and take the baseline photographs breached this part of the Code and this breach is serious such that it amounts to professional misconduct. Ms Stewart submitted that this is an omission that falls short of what was proper in the circumstances and that it would have been proper to complete the first entry in Patient A's wound care and Wound Assessment chart with complete information.

Ms Stewart submitted that a failure to take a baseline photograph fell short of what was required in the circumstances. She submitted that the chart indicated that a photograph should be attached and that it should be completed on assessment at least on a monthly basis or when there is a significant change. She further submitted that these photographs are a baseline which assess the progress of the wound and that the failure to take these photographs led to the Patient requiring further amputation surgery and therefore, led to serious misconduct.

Ms Stewart submitted that the panel have regard to the totality of the circumstances, which resulted in the patient requiring further amputation. She submitted that you also breached sections 6 and 8 of the Code on more than one occasion by way of your misconduct in relation to charges 1a and 1b.

In relation to charge 2, Ms Stewart submitted that you had a duty to complete accurate records after the wound dressing, when measuring the wound and recording the condition of the wound. She submitted that you failed to comply with these sections of the Code due to your omissions which fell short of what would be proper in the circumstances. Ms Stewart submitted that it would have been appropriate for you to consider the contents of the wound care and wound assessment charts and that you also had a duty to document the reason for the change of dressing and provide details on the progress notes. She

submitted that you did not indicate in your notes whether there was a change of the care plan and therefore provided incomplete and inaccurate information on the Form.

Therefore, in relation to charge 2, Ms Stewart submitted that there were several breaches of the Code and that these have been breached on more than one occasion, which thereby amount to serious professional misconduct.

In connection with charge 4, Ms Stewart submitted that this relates to the care records and the documentation of the condition of the wound. She submitted that it is a fundamental tenet of nursing to have accurate record keeping. She also submitted that you breached section 8.3 of the Code as you had a duty to keep colleagues informed when providing care to patients and communicating with other healthcare professionals. Ms Stewart submitted that it would have been appropriate for you to complete the charts comprehensively, to clarify the condition of the wound from one day to the next, so that you could inform your colleague of the care the Patient received.

In connection with charge 5, Ms Stewart submitted that this relates to the issue of communication. She submitted that you breached section 6 of the Code as the information you relayed to Colleague A was inaccurate, given that you had not changed the dressing for 10 days prior to your communication with Colleague A and that the only way you would have known about the condition of the wound was to have read the notes. She submitted that Witness 1 gave evidence that the note on 14 May 2020 did not reflect what was told to her by you. Therefore, Ms Stewart submitted that you did not work cooperatively or practise safely as required by the Code.

Lastly, in relation to charge 6, Ms Stewart submitted that you failed to provide accurate information and failed to communicate and escalate matters. Therefore, she submitted that you conducted yourself in a way that put Patient A at risk of harm and that you also undermined the confidence of the members of the public in the profession as well as your colleagues.

Submissions on impairment

Ms Stewart 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).

Ms Stewart submitted that three years have elapsed since the incident and she referred to Witness 1's evidence where she stated that you are no longer working as a nurse and have left the country. Ms Stewart submitted that the panel have heard no evidence from you regarding your insight into the matter and to demonstrate whether you have strengthened your practice. Ms Stewart acknowledged that you made admissions to some of the charges but submitted that this was not accompanied by your insight. Therefore, Ms Stewart submitted that there is no evidence to show that you have remedied the regulatory concerns raised against you.

You stated that you accept you made mistakes and that you were sorry for what has happened. You said that you hope that everything will return to normal and that you plan to work as a nurse in the United Kingdom (UK). You said that you have worked in many places and never made any mistakes or received any complaints throughout your time working as nurse.

You said that you worked as an agency nurse and only worked on a couple of shifts either once or twice a week. You said that there were other permanent nurses on shift who were also involved in Patient A's wound care. You said that no one mentioned about the infection until two weeks later you found out from your manager over a phone call that this was your responsibility as you were taking care of Patient A's dressing.

You found this unfair as you were not the only nurse on shift. You stated that you would like to prove that you are good nurse and that you plan to return to the UK to carry on practising as a nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. This included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311.

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 and also referred itself to the NMC Guidance entitled '*Misconduct'* referenced as FTP- 2a last updated on 29 November 2021, in particular:

> *"The Code sets the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that patients and public tell us they expect from nurses, midwives and nursing associates. While the values and principles can be interpreted for particular practice settings, they are not negotiable."*

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. The panel was satisfied that the clinical concerns either admitted by your or found proved, contributed to harm suffered by Patient A. The panel found that your misconduct breached the following sections of the Code:

> ***1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively.*

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively.

8 Work cooperatively

To achieve this, you must:

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.

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

In relation to charge 1, the panel considered your failure to complete an accurate assessment on Patient A's wound on 24 April 2020 as amounting to serious professional misconduct. The panel was of the view that this Patient was vulnerable having been admitted to the Home after an amputation procedure. The panel were also informed that Patient A was a [PRIVATE]. Patient A was high risk given her underlying [PRIVATE], had full capacity and insight into her vulnerabilities regarding wound healing. The panel was of the view that the failure to carry out the initial assessment and/or complete accurate assessment of Patient A's wound along with taking baseline photographs (as required in the Form/care plan), had the potential to impact on the ability to monitor the healing and the journey of the wound. The panel determined that your conduct fell short of the standards expected of a nurse as this was basic nursing care. As you did not take baseline information during the initial assessment and considering the vulnerabilities of this Patient, this impacted on the story of the wound deteriorating, making it difficult to detect early changes happening, which would inhibit escalation and early intervention in a timely manner.

In relation to charge 2, the panel determined that the accuracy of record keeping is a fundamental of nursing care and therefore, by failing to take detailed accurate records, this fell far short of the standard expected of a registered nurse. It is incumbent on you to keep accurate records in order to mitigate the risk of harm. The panel determined that this amounts to serious professional misconduct on the basis that it would be difficult to map the journey of the wound as a result of poor record keeping.

With regard to charge 4, the panel determined that for the same reasons as above, your poor record keeping constituted serious professional misconduct. By recording information, which did not accurately reflect the condition of the wound, this would inhibit

other healthcare professionals to monitor the wound and take appropriate clinical action to provide effective care as or when required.

The panel determined that charge 5 amounts to serious professional misconduct as the patient was put at risk by you providing incorrect information. The panel was of the view that you provided inaccurate information to a consultant working with amputees in a rehabilitation setting. The purpose of the conversation was to assess the patient's suitability for a compression stocking to be placed at end of the stump to reduce the swelling. By providing inaccurate information, this misled the consultant who was planning the next stage of the rehabilitative treatment, which was not appropriate at this stage because of the condition of the wound. This directly impacted on the recovery of Patient A.

Lastly, in relation to charge 6, the panel determined that failing to communicate clearly in these circumstances, amounted to serious professional misconduct. You were provided with the opportunity to provide clinical information about Patient A's wound at the weekly clinical meeting and you failed to do so, and later when questioned, you provided confusing information, therefore causing an increased risk of harm to Patient A.

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

Decision and reasons on impairment

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

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

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 also referred itself to the NMC's guidance document entitled, "*Impairment*" referenced DMA-1 last updated on 27 March 2023. The panel found limbs a, b and c above engaged.

The panel finds that the patient was put at risk and was caused harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel considered, as a result of your misconduct, whether you could "*practise kindly, safely and professionally.*"

Regarding insight, in your closing submissions, you informed the panel that "*I know I did some mistakes*." It was of the view that this demonstrated limited insight into your failings and there was no evidence before the panel to demonstrate whether you have strengthened your practice to reassure the panel that this would not likely be repeated in the future.

The panel was of the view that there is a risk of repetition due to the lack of evidence of strengthened practice, there is no reflective statement from you to demonstrate how you would attend to the situation differently in the future and your reflection on your conduct generally. Therefore, the panel determined that the risk of harm remains the same as there is nothing to show that this risk has reduced due to your lack of insight. The panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. It was of the view that a fully informed member of the public would be shocked by your part in the care undertaken at the Home and would expect professional standards and conduct to be upheld accordingly. The panel concluded that public confidence in the profession would be undermined if a finding of

impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest. Therefore, the panel determined that a finding of impairment on public interest grounds is required.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of up to one year. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Ms Stewart submitted that a suspension order for 12 months with review would be the most appropriate sanction as the misconduct is too serious for no action to be taken and it is not at a lower end of the spectrum. She submitted that a conditions of practice order would also not be appropriate in the circumstances.

In terms of the charges found proved, she submitted that these concern a failure to take an accurate assessment of a patients wound, accurately complete care charts on more than one occasion (over a period of time), and relaying an inaccurate description of the wound to Colleague A and other colleagues working with you.

Ms Stewart submitted that your actions put patients at risk of harm and brought the nursing profession into disrepute, which would therefore have impacted on public confidence.

Ms Stewart submitted that the charges found proved took place over a relatively long period of time and you had the opportunity to address these concerns, but did not do so. She submitted that you have not provided any insight into your actions and that you should have explained what went wrong or why or what you could have done differently. She also submitted that you are not undertaking any training in connection with the matters, such as wound care or record keeping. On that basis, Ms Stewart submitted that a conditions of practice order would not be suitable in all the circumstances and that the appropriate sanction would be one of a suspension order for a period of 12 months.

The panel also bore in mind your submissions where you stated that you worked as a permanent nurse in Scotland for three years and that after three years, when your English and your skills had improved. Since 2018, you said you worked with a couple of agencies where you worked in more than 60 or 70 places in the UK and that you received no complaints from those organisations.

You accepted that you made some mistakes, but explained that you were not the only nurse on duty as there were other nurses who were also in charge of the wound dressing and on the care plan notes, where it was recorded as '*no signs of infection*.'

You stated that you worked as a nurse in Romania for 1.5 years since these allegations but that you are currently running your own business repairing refrigerators and air conditioning units. You said that you have been checking online and that you are aware of the revalidation process. You explained that you would like to be provided with another chance to prove that you are a good nurse as nursing is your passion. You intend to return to the UK to continue to practise as a nurse. When asked about whether you would comply with the conditions of practice, you stated that you will do all the training that is necessary and will do everything that is asked of you by the panel in this hearing.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into failings;
- A pattern of misconduct over a period of time;
- Conduct which put patients at risk of suffering harm;
- No attempt to address the failings/misconduct;
- Panel cannot be reassured that something similar may not happen again the future; and
- No evidence to show that you can practise safely.

The panel also took into account the following mitigating features:

- You were not the only nurse looking after Patient A and other nurses also had poor record keeping, therefore you were not solely responsible for the failings; and
- The event occurred during the COVID-19 pandemic, which caused additional complexity in looking after residents at the Home.

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be relevant, proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice and determined that workable and measurable conditions can be put in place.

The panel had regard to the fact that these incidents happened some time ago and was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order would be disproportionate and would not provide you with re-training opportunities to demonstrate insight and strengthened practice.

Having regard to your misconduct, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer’s contact details.

2. You must keep us informed about anywhere you are studying by:

a) Telling your case officer within seven days of accepting any course of study.
b) Giving your case officer the name and contact details of the organisation offering that course of study.

3. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).
   c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

4. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

5. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

6. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from:
   a) your line manager.
   b) mentor or supervisor.

7. You must limit your nursing to a single employer which must not be an agency.

8. You must ensure that you are supervised by a registered nurse of band 6 or above any time you are working. Your supervision must consist of:
    - Working at all times on the same shift as, but not always directly observed by, a registered nurse of band 6 or above.
    - Bi weekly meetings with your supervisor who should be a registered nurse of band 6 or above to discuss your progress, with a particular focus on record keeping and wound management.

9. You will send your case officer evidence that you have successfully completed accredited courses on record keeping and wound management within 3 months of commencing employment.

10. You must work with your supervisor to create a personal development plan (PDP). Your PDP must address the concerns about record keeping and wound management. You must:

    • Send your case officer a copy of your PDP within 7 days of commencing employment.

    • Send your case officer a report from your supervisor every month. This report must show your progress towards achieving the aims set out in your PDP.

11. You must engage with your supervisor on a frequent basis to ensure that you are making progress towards aims set in your personal development plan (PDP), which include:

    • Meeting with your supervisor bi weekly to discuss your progress towards achieving the aims set out in your PDP.

The period of this order is for up to 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Evidence of professional development, including documentary evidence of completion of the above mentioned courses, and testimonials from a line manager or supervisor that detail your current work practices.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Stewart. She submitted that an interim conditions of practice order for 18 months is necessary on the grounds of public protection and the wider public interest and that this will cover the appeal period of 28 days.

Ms Stewart submitted that this order will fall away in the event that no appeal is made and the conditions of practice order becomes effective.

You indicated that you do not oppose the imposition of the interim order.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order in the same terms 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 noted that there has been no evidence presented to it to show whether you have strengthened your practice in the last three years since the incident. The panel therefore determined that an interim conditions of practice order for a period of 18 months is necessary. The panel also determined that if an interim order is not made, it would be inconsistent with its findings and the concerns identified regarding your practice.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive order made 28 days after you have received the decision of this hearing in writing.

This decision will be confirmed to you in writing.

That concludes this determination.