Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

23 April – 7 June 2019 & 17 June – 30 July 2019

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Debbie Doreen Moore
NMC PIN:	80I2065E
Part(s) of the register:	Registered Adult Nurse – December 1982 Nurse Independent / Supplementary Prescriber – January 2007
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Emma Boothroyd (Chair, Lay member) Kitty Lamb (Registrant member) Eileen Skinner (Lay member)
Legal Assessor:	Nigel Mitchell
Panel Secretary:	Caroline Pringle
Mrs Moore:	Present and represented by Leila Chaker, instructed by the RCN
Registrant A:	Present and represented by Mary-Teresa Deignan, instructed by the RCN
Registrant C:	Present and represented by Claire Robinson, instructed by the RCN
Registrant D:	Present and represented by Anna Chestnutt, instructed by the RCN

Nursing and Midwifery Council:	Represented by Michael Collis, Case Presenter
Outcome:	No case to answer under Rule 24(7) in relation to all charges

Details of charge

That you, a registered nurse, whilst working as the Head of Healthcare at HMP Liverpool, Liverpool Community NHS Trust, between 2011 and 2014, you:

1. In relation to the healthcare service provided to HMP Liverpool (the Prison), failed to adequately escalate and/or take adequate action in respect of:

a) Reports of inadequate care to patients, in particular;
   i) Failures to ensure attendance at appointments and/or following up missed appointments;
   ii) Failures to make appropriate and/or timely referrals to manage identified health conditions and/or long term conditions;
   iii) Failures to conduct observations and/or monitoring and/or testing in relation to known health conditions and/or long terms conditions;

b) Reports of inadequate care plans and/or failures to consistently create care plans, particularly in relation to:
   i) Long term health conditions;
   ii) Weight management;
   iii) Skin integrity;
   iv) Risk of falls and/or mobility;

c) Reports of inadequate risk assessments and/or failure to consistently conduct risk assessments, particularly in relation to:
   i) Long term health conditions;
   ii) Weight management;
   iii) Skin integrity;
   iv) Risk of falls and/or mobility;
   v) Requirements for restraints during external hospital visits;

d) Reports of inadequate patient record keeping;

e) Reports of concerns in respect of medicines management and/or the administration of medication;

f) Reports of inadequate management of controlled drugs and/or the administration of controlled drugs;

g) Reports that supervised methadone was not being properly supervised or controlled;

h) Reports that health screening/assessments and/or secondary health checks for new and/or returning prisoners/patients were not being completed and/or were not being completed adequately;

i) Reports of insufficient staffing levels within the prison and/or lack of training opportunities for staff;

2. Failed to ensure Trust level investigations were conducted into the Deaths in Custody (DICs) of one or more patients, including:

a) Patient A; and/or
b) Patient B; and/or
c) Patient C and/or
d) Patient D;

3. Failed to ensure Serious Untoward Incident reports were conducted following deaths in custody in respect of one or more patients, including:

a) Patient A; and/or
b) Patient B; and/or

c) Patient C and/or

d) Patient D;

4. Discouraged staff from reporting adverse incidents and/or submitting Datix reports on one or more occasions;

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

Background

From 1 November 2010 until January 2015, Liverpool Community Health NHS Trust ("the Trust / LCH") held a contract to provide healthcare services at HMP Liverpool ("the Prison"). You were employed by the Trust as Head of Healthcare at the Prison until mid-2014.

You were supported by two Service Managers, Registrant C and Registrant D. Together, you face identical charges which allege a number of failures in respect of healthcare provision, risk management and incident reporting within the Prison.

Application for Ms 19 to give evidence via videolink

Mr Collis made an application for Ms 19 to give evidence via videolink. He informed the panel that Ms 19 was unable to attend the hearing in person due to her health and provided the panel with a letter from Ms 19's GP, dated 12 April 2019, and a summary of a consultation on 21 March 2019. The letter confirmed that Ms 19 is [PRIVATE] and unable to participate in a hearing. However, Mr Collis informed the panel that the NMC has been in contact with Ms 19 and she does feel able to participate remotely, by way of videolink.

Mr Collis summarised Ms 19's evidence and submitted that her evidence was relevant to the charges and provided a helpful overview of the management structure at the Trust.

The application was not opposed by your representative, nor by any of the other three registrants in this case.

The panel accepted the advice of the legal assessor, who referred it to Rule 31. 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. He

further referred the panel to the cases of Shodlok v GMC [2013] EWHC 2280 (Admin) and Polanski v Conde Nast Publications [2005] 1 WLR 637.

The panel decided to allow the application. It was satisfied that Ms 19's evidence was relevant to the charges and there was a good reason for her being unable to attend in person, which was supported by medical evidence. The panel was also satisfied that it was fair for Ms 19 to be allowed to participate remotely. She is an important witness to these allegations and it is in the interests of justice that her evidence is heard. Furthermore, the videolink will allow her to be seen and heard in the same way as if she were physically present in the room, and her evidence can still be tested by cross-examination.

In these circumstances, the panel was satisfied that it would be fair to allow Ms 19 to give evidence by video link.

It therefore allowed the application.

Decision and reasons on application under Rule 19

During Colleague C's evidence, Ms Deignan made an application to ask some questions in private, as they related to Colleague C's health and other personal issues. The application was made pursuant to Rule 19 of the Rules.

This application was not opposed.

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 read Colleague C's witness statement, the panel was aware that there were parts of her evidence which related to her health and other sensitive personal matters. The panel was satisfied that Colleague C's right to privacy in relation to these matters outweighed the interest in a public hearing. The panel therefore determined to hold such parts of the hearing in private.

The panel later determined to hear parts of the evidence from other witnesses in private, for the same reasons.

Application to adjourn the evidence of Mr 24

Mr 24 was scheduled to give evidence at this hearing on 25, 26 and 27 June 2019. On the morning of 25 June, Ms Chaker made an application, on your behalf, to adjourn his evidence.

Ms Chaker informed the panel that a subject access request had been made to Mersey Care NHS Foundation Trust (who had taken over from Liverpool Community NHS Trust) in advance of this hearing. At the time, your representatives had been informed that no documents existed which matched their search criteria. However, last week the NMC received additional material obtained from Mersey Care, via a Freedom of Information request made by a third party. As a result of this material, your representatives renewed their original subject access request and this morning were informed that in fact 1500 items of data exist which match the requested search criteria.

Ms Chaker submitted that this data may be of significant importance to your defence and contain matters which ought to be put to Mr 24. She therefore made an application that she not be compelled to start her cross-examination of Mr 24 until she had had a chance to receive and review this data. Ms Chaker informed the panel that she had not yet received the data, as Mersey Care were required to undertake a redaction process for data protection reasons before they could disclose the information. She therefore

requested that Mr 24's evidence be postponed until 09:30 the following morning (26 June) in order for further enquiries to be made.

Ms Deignan and Ms Robinson, on behalf of Registrant A and Registrant C, respectively, supported the application to postpone until 09:30.

Ms Chestnutt, on behalf of Registrant D, opposed the application to postpone Mr 24's evidence.

Mr Collis, on behalf of the NMC, recognised that the original request was made to Mersey Care in good time and was sympathetic to your current position. He submitted that, if the hearing was in a position to commence Mr 24's evidence at 10:00 the following morning, there was a realistic prospect of completing his evidence in the remaining allocated time and therefore postponing his evidence until 09:30 tomorrow should not cause significant delays to the hearing progress.

The panel considered the submissions made by the parties and the advice of the legal assessor. It noted that the original request had been submitted to Mersey Care in good time and no fault could be attributed to any of the parties present for the current situation. It considered that it would be unfair to require Ms Chaker, or any of the other advocates, to commence cross-examination of Mr 24 without having had the opportunity to review this new information. It also bore in mind that Mr 24 was warned for another two days and, if the documentation could be obtained by tomorrow, then it may still be possible to conclude his evidence.

The panel therefore decided to adjourn the hearing until 09:30 the following morning (26 June 2019).

The next day Ms Chaker informed the panel that your representatives had been in communication with Mersey Care however the documentation had not yet been disclosed, nor did she have a time estimate for when this was likely to happen.

However, she informed the panel that it had been confirmed that many of the 1500 items did relate to Mr 24 and were therefore likely to be of real significance to your defence. Ms Chaker further submitted that, once she had received the documents, she estimated that she was likely to require a minimum of three working days to review the information and take instructions.

Ms Chaker therefore made an application to adjourn Mr 24's evidence until 8 July 2019 (when Mr 24 was next available to give evidence). Ms Chaker submitted that the intervening time could be put to good use preparing written submissions for the no case to answer application, which she intended to make once the NMC has closed its case.

Ms Robinson, on behalf of Registrant C, supported the application to adjourn Mr 24's evidence until 8 July and submitted that she also intended to make a no case to answer application and could use the time to prepare written submissions, which would minimise any delay at a later stage.

Ms Chestnutt, on behalf of Registrant D, did not oppose the application. She submitted that the time could be used to continue the process of agreeing facts with the NMC, which was already underway.

Ms Deignan, on behalf of Registrant A**,** raised a number of concerns and possible prejudices which could be caused to Registrant A by the disclosure of this information and any consequent delays, but submitted that she could not start her cross-examination of Mr 24 until she knew the content of the documents.

Mr Collis, on behalf of the NMC, accepted that given the volume of material further delay was inevitable and did not oppose an adjournment of Mr 24's evidence until 8 July.

The panel accepted the advice of the legal assessor who referred it to Rule 32(4) which provides that a panel can adjourn a hearing at any stage providing it causes no injustice

to any of the parties. He further advised the panel regarding the matters it should take into account when considering an application to adjourn. These include the public interest in the expeditious disposal of the case, the potential inconvenience caused to any of the parties, and fairness to the registrants.

The panel decided that it was fair to adjourn the evidence of Mr 24 until 8 July 2019. It noted that a delay at this stage was regrettable, but was through no fault of any of the registrants, nor the NMC. You knew this material existed and believed that it would be helpful to your defence, and the initial request was submitted in good time. Unfortunately you were incorrectly informed that it did not exist. Now that the information has come to light, the panel decided that it would be wholly unfair for Ms Chaker, or any of the other advocates, to compel them to cross-examine Mr 24 without first reviewing this new information. The panel was also reassured that the parties would use the adjourned period to prepare their no case to answer submissions, thereby saving time later on in the hearing. The panel recognised that an adjournment would require Mr 24 to return, and therefore cause him inconvenience. However, it was satisfied that, in these particular circumstances, the proposed adjournment was proportionate and necessary to ensure fairness to you and the other registrants.

Application to adjourn proceedings until 18 July 2019

During the week's adjournment that was granted to secure further documents from the Trust, the panel was reconvened on 4 July 2019 to hear an application from Ms Deignan. This application was heard entirely in private.

[PRIVATE].

The panel rejected the application.

Application to admit a further document into evidence under Rule 31

Prior to closing the NMC's case, Mr Collis made an application to adduce an additional document into evidence. He informed the panel that, during the course of this hearing, the NMC had received a number of additional documents from a third party, obtained from the Trust via a Freedom of Information request. One of the documents, which the NMC now sought to admit into evidence, was an email sent by Registrant A on 4 May 2012 to a number of Trust staff (some of whom had been called as witnesses in this hearing).

Mr Collis informed the panel that the email related to CIPs and the vacancy control panel. He submitted it was therefore relevant to the charges in this case concerning CIPs and staff shortages. He submitted that the document supported the oral evidence given by witnesses and it did not introduce any new issues. He therefore submitted it would be fair to allow the NMC to introduce the document, particularly since it had recently been provided by a third party and was not a document that was available to the NMC previously.

Ms Deignan, on behalf of Registrant A, opposed the application. She submitted that it would be unfair to admit it into evidence for a number of reasons and provided the panel with written submissions to this effect. Ms Deignan submitted that directions had been made prior to this hearing that the NMC would serve its proposed hearing bundle and case summary to each of the registrants by 14 November 2018, in order that the registrants could prepare their cases. Ms Deignan submitted that to introduce new evidence at this stage would 'radically' change the case against Registrant A and be unfair. She submitted that, if the panel allowed this email into evidence, then she may be required to recall some of the witnesses. She outlined to the panel the specific areas of questioning which would arise from this document.

Ms Deignan also submitted that it would be unfair to admit the email into evidence because, as it had been obtained by a third party and not through the NMC's

investigation, the NMC had not had to go through the process of establishing if there was any further evidence which undermined its case or assisted Registrant A's.

Ms Chaker, on your behalf, supported the NMC's application to adduce the email into evidence. She submitted that the email was directly relevant to your culpability, as well as that of Registrant C and Registrant D, in relation to managing staffing shortages and supported the oral evidence that had already been given by a number of witnesses.

Ms Robinson, on behalf of Registrant C, supported the NMC's application and adopted the submissions of Ms Chaker.

Ms Chestnutt, on behalf of Registrant D, was neutral on the application.

The panel accepted the advice of the legal assessor who referred it to Rule 31. 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 considered the submissions and the advice of the legal assessor. It noted that the email concerned CIPs and the vacancy control panel. The panel was therefore satisfied that the email was directly relevant to charges 1, 2(a), 3(a) and 5(d)(vii), as faced by Registrant A, and charge 1(i) as faced by you, Registrant C and Registrant D.

The panel therefore moved on to consider the issue of fairness. It was of the view that the issues raised in the email, namely CIPs and the vacancy control panel were topics which had been explored at length with Dr 20, Ms 19 and the divisional leads when they gave their oral evidence. As such, the panel did not consider that the contents of this email introduced any materially new information to the proceedings, nor did it unfairly change the case against Registrant A.

The panel had regard to the directions given at previous preliminary meetings, regarding the deadlines by which the NMC was to serve its evidence. However, it was

mindful that this email had been produced, not as a result of further or ongoing enquires by the NMC, but by a third party. It also had regard to its primary role of public protection, and considered that it was important that the panel was provided with relevant information where it was available.

The panel therefore concluded that it would be fair to allow the email into evidence. While the panel was of the view that the issues raised within the email had already been sufficiently explored with the relevant witnesses in cross-examination, it would be open for Ms Deignan, on behalf of Registrant A, to recall any witnesses if there were matters arising specifically from the admission of this document or, alternatively, deal with the matters in submissions or through any evidence given by Registrant A.

The panel therefore allowed the application.

Application of no case to answer

Ms Chaker, on your behalf, made an application that there was no case to answer under Rule 24(7) in respect of all of the charges against you. Ms Chaker provided written submissions in support of her application.

Mr Collis also provided written submissions, in which he set out the NMC's response to Ms Chaker's submissions on each charge.

The panel accepted the advice of the legal assessor who referred it to Rule 24(7) of the Rules and R v Galbraith [1981] 1 WLR 1039.

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

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether

sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel decided that there was no case to answer on any of the charges against you.

The reasons for its decision in relation to each charge are set out below.

In her written submissions, Ms Chaker outlined five elements which she submitted must be established in order for there to be a realistic prospect of finding charge 1, and all of its sub-charges, proved:

i. That there was a report of a particular concern;
ii. The report was received by you between 2011 - July 2014
iii. Arising from the concern identified in the report, there was a duty on you to take action and/or escalate;
iv. There is an identifiable standard that you were expected to meet in discharging that duty – i.e. what would have amounted to adequate escalation and/or adequate action?
v. That whatever action / escalation you did take following the report of the concern was not adequate – i.e. what did you in fact do/not do?

The panel accepted this submission, and bore these five elements in mind when considering charges 1(a) – 1(i).

Charge 1(a)(i): Failures to ensure attendance at appointments and/or following up missed appointments

The panel noted that the NMC's evidence in support of this charge came from a series of reports made by external organisations. The first of these was a report by Prisons and Probations Ombudsman ("PPO") inspector Mr 1 into the Death in Custody ("DIC") of Patient A, published in October 2013. This report raised concerns about a "series" of missed appointments. However, in cross-examination he accepted that he had made some typographical errors in his report and that the most he could say after reviewing

his statement and report is that Patient A may have missed one appointment with a neurologist in July 2011 and one appointment with the prison nurse on 27 February 2012.

Her Majesty's Prisons Inspectorate ("HMIP") inspected the prison in October 2013. Mr 8, a senior and experienced HMIP inspector, also identified missed appointments as a concern within the Prison. He reported that the rate of missed appointments at the time of his inspection was 41% which was higher than the national average and recommended that 'failure to attend rates for clinic should be reduced to a minimum'. However, in his oral evidence he was also clear about the challenges of ensuring attendance at appointments in a prison as busy as HMP Liverpool. He agreed that prisoners and prison officers, who facilitated attendance at appointments, would often prioritise other elements of the core day, or appointments would clash with other commitments such as visits from legal representatives and family members. He noted that control over the movement of prisoners from the wing to the healthcare unit was held by prison staff (as opposed to healthcare staff) whose principle focus was security. On the whole, Mr 8 gave a clear description of the multitude of reasons for this higher rate of missed appointments, many of which were beyond the control of you or any of the other healthcare staff at the Prison.

Notwithstanding this, when the CQC inspected the prison in March 2014 it noted significant improvements in the rate of missed appointments. The report concluded that 'since our last inspection nursing staff had been both creative and proactive in their attempts to get prisoners to their healthcare appointments…they had started to deliver appointment slips direct to prisoners' cells and were visiting the wings. They were engaging prison operational staff in discussion about the importance of prisoners attending appointments and the impact on the service and consequences for both prisoners and healthcare staff performance if prisoners failed to attend appointments. This report also noted that staff were recording the reasons that prisoners were not attending their appointments, together with an audit of those reasons.

The panel had regard to this evidence. It was satisfied that there was evidence of concerns being raised in 2013 regarding missed appointments at the Prison. However, there was also evidence that you took action to address these concerns, which resulted in the improvement noted by the CQC in March 2014.

The panel noted that you had been seconded to other roles external to the Prison from January – November 2013 and in addition had periods of sickness absence in the same year. Despite this, you continued to attempt to address issues at the Prison. The panel heard evidence that these secondments and the extra responsibility at HMP Kennett that was delegated to you significantly impacted on the time available to you to be carrying out your role at the Prison.

The issue the panel therefore had to consider was whether there was sufficient evidence to establish that you failed to adequately escalate and/or take adequate action in respect of missed appointments. The panel had regard to Mr Collis' submissions. In these submissions, he argued that Ms 10 identified a repetition of this concern in May and June 2014, and therefore the repetition of concerns regarding missed appointments suggested that the action taken by you, Registrant C and Registrant D was inadequate.

The panel could not accept this line of logic. Taking account of the extensive and unchallenged evidence it had heard from numerous witnesses regarding the unique challenges of the prison environment and the number of external factors which impeded the healthcare team's ability to provide care to prisoners, it was not satisfied that evidence of repetition of a concern was necessarily evidence that it had not been escalated or that the action taken to address that concern by you was in itself inadequate. In addition, the panel heard evidence that by September 2012 there was an increase in the number of prisoners being admitted to HMP Liverpool from 250 to 500 per month. There was no increase in funding or staff in order to deal with the health needs of these additional prisoners. There was further evidence that there was an increase in the complexity of the health needs of these prisoners.

The panel was unable to infer that because there was a repetition of a reported concern this was determinative of an inadequate response by you. The panel heard evidence that you were reporting and escalating concerns and there were significant challenges facing healthcare delivery that were outside your control. The panel also heard evidence and saw a CQC inspection report dated December 2014, which was after your departure from the Prison. This report highlighted the same concerns and in fact showed that standards had deteriorated significantly since the previous inspection in March 2014 when all standards were met for the Prison's health suite. The panel considered that this further undermined the submission that repetition of the concern was because of inadequate action or escalation on your part.

Furthermore, the NMC had provided no evidence of what would have amounted to adequate escalation or adequate action. The panel therefore had no satisfactory evidence that your escalation or actions in respect of missed appointments in the Prison were inadequate.

Accordingly, it determined that there was no case to answer in respect of charge 1(a)(i).

Charge 1(a)(ii): Failures to make appropriate and/or timely referrals to manage identified health conditions and/or long term conditions

The panel noted that the NMC's evidence in support of this charge came from:

- Ms 2's PPO report into the DIC of Patient B in September 2012
- Mr 1's PPO report into the DIC of Patient A in October 2013
- Mr 1 and Ms 6's PPO report into the DIC of Patient C in June 2014

In her written submissions, Ms Chaker submitted that Ms 2's PPO report was not relevant to this charge. Ms 2's criticism in Patient B's case was that his cancer was not identified at an earlier stage. Whilst it was accepted that this may be a concern in itself, it was submitted that the charge requires there to have been an identified long-term condition and therefore Ms 2's evidence was not relevant. The panel noted that Mr

Collis, in his submissions, accepted this and submitted that the NMC was no longer seeking to rely on Ms 2's PPO report in respect of this charge. The panel accepted the submissions put forward and therefore determined that Ms 2's evidence was not relevant to its decisions on this charge.

Ms Chaker also submitted that Mr 1 and Ms 6's PPO report into the DIC of Patient C was not relevant to this charge. It was submitted that this report made no criticism of Patient C's referrals and were complimentary about this aspect of his care. The panel accepted this submission. It also had regard to Ms 6's oral evidence in which she commented that prisoners of Patient C's age, frailty and complexity were "practically unheard of" in a Category B prison (such as HMP Liverpool), meaning that he required a very high level of clinical intervention. She confirmed in her evidence that this care was provided to Patient C and appropriate referrals were made. She also gave evidence that efforts were made by the healthcare team at the Prison to transfer Patient C to a prison which could better meet his healthcare needs, but this was unsuccessful. In light of this evidence, Mr Collis accepted that the NMC was no longer seeking to rely on Patient C's PPO report to support the charge. He further submitted that in the absence of repetition of the concerns identified in the PPO report for Patient A, the panel was unlikely to find that there was sufficient evidence to support this charge.

In relation to Mr 1's PPO report into the DIC of Patient A, the panel noted that the report concluded that the GP who examined Patient A on 27 June 2011 should have considered an emergency admission. The report recommended that 'the Head of Healthcare should ensure that prisoners are referred to hospital whenever there are significant concerns about their health'. However, in his oral evidence Mr 1 confirmed that the failure to consider an emergency admission was a clinical decision made by the doctor. The panel considered that it could not attribute criticism of this clinical decision made by an individual doctor to a failing on your part. Furthermore, the Trust's Medical Director, Dr 20, confirmed in his oral evidence that following this report you worked closely with his deputy to improve standards amongst the GPs who worked at the Prison and to ensure that they were receiving appropriate clinical supervision.

Having regard to all of the evidence it had heard, the panel was not satisfied that the NMC had produced any evidence that would properly allow it to conclude there were concerns in the Prison regarding appropriate and/or timely referrals to manage identified health conditions and/or long term conditions and that you had failed to adequately escalate or take adequate action in respect of these concerns.

Accordingly, the panel determined that there was no case to answer in respect of charge 1(a)(ii).

Charge 1(a)(iii): Failures to conduct observations and/or monitoring and/or testing in relation to known health conditions and/or long term conditions

The panel noted that the NMC's evidence in support of this charge came from the PPO report into the DIC of Patient C, produced by Mr 1 and Ms 6 in June 2014. However, the panel also heard evidence that the Coroner's Inquest into Patient C's death recorded as a 'matter of concern' that 'it was clear that the PPO report and Clinical Review had not been sent to, nor shared with, the Healthcare provider at HMP Liverpool'. This evidence was not challenged. During cross-examination, Ms 6 confirmed that if the reports were not shared with you then the criticism she made of you in her NMC witness statement was unfair.

In his submissions, Mr Collis accepted that there was a degree of evidential uncertainty as to whether or not the full extent of the concerns raised by Ms 6 in respect of observing/ monitoring / testing in relation to known health conditions and/or long term conditions were communicated to you. He further acknowledged that, in these circumstances, the panel may have difficulties in determining that there was sufficient evidence to support the assertion that the concerns in respect of charge 1(a)(iii) were communicated to you.

The panel determined that the NMC had produced no evidence that you were aware of Ms 6's concerns regarding a failure to conduct observations and/or monitoring and/or testing in relation to known health conditions and/or long term conditions. In light of this, it cannot be said that you had a duty to take action and/or escalate these concerns and therefore no realistic prospect that the panel would find the charge proved.

Accordingly it determined that there was no case to answer in respect of charge 1(a)(iii).

Charge 1(b)(i): Inadequate care plans and/or failures to consistently create care plans in relation to long term health conditions

The panel noted that, in opening its case, the NMC sought to rely on number of reports in support of this charge, including:

- Ms 6's PPO Clinical Review into the DIC of Patient C, June 2014
- Mr 2's HMIP report, October 2013
- Ms 25's CQC report, October 2013
- Ms 7's PPO Clinical Review into the DIC of Patient D, April 2014
- Ms 10's inpatient audits, January 2014 and August 2014

The panel noted the NMC had not provided it with examples of any care plans.

The panel noted that the only mention of care planning in Ms 6's clinical review is a generic comment about the importance of care planning. No mention is made of any specific deficiency in Patient C's care plans. Although she makes various criticisms of the management of Patient C's long-term conditions, she does not say whether this was because Patient C did not have a care plan for these conditions, or whether the care plans were of a poor standard, or whether this was as a result of nurses not following the care plan properly.

However, Ms 6 did give oral evidence about the essential role of a long-term conditions nurse in care planning for patients. She confirmed that the role is a specialist position at

Band 7 level, and that it requires a minimum of 12 months training. She told the panel that it was not a role in which another nurse can ‘back fill’ or ‘act up’ unless they have completed the relevant training. This evidence was not challenged and was, in fact, corroborated by a number of other witnesses.

Mr 8’s HMIP report from October 2013 identified no concerns regarding care plans for inpatients, but noted that there was a lack of care plans for prisoners with long-term conditions. However, his report also cited staff shortages as a primary reason for the lack of outpatient care plans for prisoners with long-term conditions: ‘the long-term conditions clinics did not take place owing to staff shortages; patients with chronic conditions were dispersed to other clinics. This meant that patients did not have care plans, although the care they received met national guidance’. He confirmed in his oral evidence that he was referring in particular to the near-permanent absence of a long-term conditions nurse, whose position had been vacant for more than a year at the time of his inspection. He further confirmed that instead of visiting the long-term conditions clinic as previously would have been the case, those with long-term conditions went to other clinics and saw the GPs. At those clinics, patients received the care they would otherwise have been getting, albeit not under the guidance and management of a formal care plan. He said that he saw no examples of patients being deprived of care as a result of not having a written care plan.

Ms 25’s CQC inspection was undertaken at the same time as Mr 8’s HMIP inspection and reached the same conclusions. She noted no concerns with inpatient care planning but identified a lack of care planning for outpatient prisoners with long-term conditions.

The panel also took account of Ms 7’s PPO Clinical Review of Patient D, which was published in April 2014 but focused on the care leading up to his death in September 2013. Her criticism of care planning is also limited solely to the period when Patient D was an outpatient, which was between 20 July – 1 August 2013 and for a few hours on 19 August 2013. She makes no criticism of any other aspect of care planning or risk assessment of his long-term conditions.

Ms 10 carried out audits of inpatient records at the Prison between January and August 2014. These audits were the only evidence put forward by the NMC of concerns in relation to inpatient care planning. However, she confirmed in her own evidence that these audit reports were never provided to you. The panel was therefore satisfied that you were not aware of any concerns regarding inpatient care planning and, as such, had no duty to respond to concerns in this respect.

The panel was satisfied that there was evidence of concerns being raised regarding outpatient care planning for long-term conditions. However, it also heard a wealth of evidence regarding the steps you, Registrant C and Registrant D took to escalate and address these issues. Ms 13, Business Development Manager at the Trust, gave evidence that as early as 2012 you went to her to ask what support could be brought into the Prison from LCH's practice nurses. Ms 13 compiled a list of relevant nurses within the Trust and tasked Registrant C with contacting them. However, by January 2013 (shortly before you left the Prison on secondment), it had been established that there was no capacity within the Trust to support the Prison health team with care planning.

Colleague D, Nurse Consultant for Older People at the Trust, gave evidence that HMP Liverpool healthcare staff were positive and proactive to obtain his support in relation to older prisoners. At their request, he developed a 'comprehensive geriatric assessment' intended for the development of care plans for this patient group. He gave evidence that from 2012 he was no longer able to provide regular support to the prison due to his commitments to Intermediate Bed Based Care Services but continued to provide 'ad hoc' support to specific cases.

The panel also had evidence of the considerable efforts you had made to escalate the chronic staff shortages within the Prison (which Mr 8 had identified as one of the major contributing factors to the lack of care planning). The panel heard unchallenged evidence regarding not only the nationwide difficulties in recruiting and retaining prison

healthcare staff, but also the specific difficulties at HMP Liverpool. As a result of Cost Improvement Plans ("CIPs") in force at the Trust, from at least May 2012 all vacancies had to be approved by a Vacancy Control Panel before recruitment could commence. The panel had evidence, in the form of emails sent by you to Mr 24 and others over the relevant period, in which you outline the severe staffing situation at the Prison and the need for additional staff. However, Mr 24, the Divisional Manager at the Trust, gave evidence that despite the fact you had escalated the absence of care plans for outpatients' long-term conditions as a 'red-rated' risk on the Trust's risk register, there was "nothing [he] could do" to address this, given the pressure on him to reduce the workforce to deliver his CIP target.

Following the publication of the CQC and HMIP reports in October 2013, the Prison did receive additional support. Mr 9**,** the Trust's Clinical Programme Manager, was allocated to HMP Liverpool between January and August 2014. He gave evidence that he was specifically recruited to address the difficulties in care planning and risk assessments at the Prison and was tasked with integrating and embedding MUST assessments, falls assessments and skin integrity assessments into the patient pathway at HMP Liverpool. His evidence was that progress, albeit slow, was being made but would probably take at least 12 months for full integration into the patient pathway. At the same time, a long-term conditions nurse was eventually appointed who prioritised work in relation to the backlog of outpatient care plans. By February 2014 the percentage of patients with long-term conditions who had a care plan was 50%; by April 2014 it was 81%; by June 2014 it was nearly 90%.

The panel also heard evidence of the project work that was being undertaken by Registrant C and Ms 26 to change the operation of System One (the Prison's electronic patient records system). Ms 26 was seconded to the Prison specifically for this project, which was designed to make System One more user friendly and enable nursing staff to find templates for care plans more easily, as well as making it mandatory for risk assessments to have been either completed or ruled out as not being necessary.

Ms 17 confirmed that she was aware of these ongoing projects and felt positive about them. In her view, they were appropriate steps to take in response to the concerns identified and she left the Prison in 2014 feeling very positive.

All of the relevant witnesses agreed that you, Registrant C and Registrant D were working extremely hard to improve the situation at the Prison. Mr 24 agreed with the suggestion that the Prison staff were “working their socks off”. Mr 9 agreed that everyone was working really hard and was “shocked” when you and Registrant C were suspended in July 2014, saying that “they had extensive experience in prison healthcare. Without their support it would have been difficult to move it forward”.

In light of the above, the panel was of the view that while there was undoubtedly some evidence of concerns in the Prison in relation to care planning for long-term health conditions, there was also an abundance of evidence of the considerable efforts that you and the rest of the health care team made to escalate and address these issues, and to mitigate the risks as far as you were able to without the provision of additional support. There was also evidence that, once you had received the support which you had been asking for, significant improvements were achieved.

In his written submissions, Mr Collis argued that there was evidence of concerns being raised, you having time to act, and yet the problems still persisting within the Prison until the summer of 2014. Although he acknowledged that the panel had heard evidence of the improvements that were made, he submitted that the issue of whether your actions were adequate was one which could be determined by the panel in its findings of fact. The panel did not accept this submission. It considered that the evidence before it suggested that you had taken all the steps you could to escalate and address the issues within the Prison in relation to long-term conditions care planning. The evidence suggested that the problems persisted until 2014 largely due to a lack of resources (which was outside of your control) and, once these resources were provided at the beginning of 2014, improvements were seen.

The panel also heard evidence and saw a CQC inspection report dated December 2014, which was after your departure from the Prison. This report highlighted the same concerns and in fact showed that standards had deteriorated significantly since the previous inspection in March 2014 when all standards were met for the Prison's health suite. The panel considered that this further undermined the submission that repetition of the concern was because of inadequate action or escalation on your part. The panel also noted that the NMC had provided no evidence of what, in its view, would have amounted to adequate escalation or adequate action. The panel therefore had no satisfactory evidence that your escalation or actions in respect of care planning for long-term conditions in the Prison were inadequate.

Accordingly, it determined that there was no case to answer in respect of charge 1(b)(i).

Charge 1(b)(ii): Inadequate care plans and/or failures to consistently create care plans in relation to weight management

The panel noted that the evidence in support of this charge came from the PPO Clinical Reviews into the DICs of Patient C and Patient D.

However, the panel had heard unchallenged evidence that Ms 6's PPO Clinical Review into the DIC of Patient C was not shared with you, Registrant C or Registrant D. Furthermore, although the Clinical Review of Patient D raised concerns about the lack of care plans for weight management, the PPO report reaches a different conclusion in relation to care planning. The panel were therefore left with contradictory evidence in relation to this issue and did not consider that, in the circumstances, there was sufficient evidence to support this charge.

Additionally, the panel took into account that the first time you would have been aware of this issue was when it was raised as part of Ms 10's audits in January 2014. The panel had regard to its earlier decision in relation to charge 1(b)(i), specifically the projects put in place in 2014 to address issues in relation to care planning and the

subsequent improvements seen. The panel also noted that the NMC had provided no evidence of what, in its view, would have amounted to adequate escalation or adequate action. The panel therefore had no satisfactory evidence that your escalation or actions in respect of care planning for weight management in the Prison were inadequate.

Accordingly, it determined that there was no case to answer in respect of charge 1(b)(ii).

Charge 1(b)(iii): Inadequate care plans and/or failures to consistently create care plans in relation to skin integrity

Having heard the evidence, the panel noted that concerns in relation to care planning for skin integrity were not raised until Ms 10's audits, conducted in the summer of 2014 shortly before you were suspended. Ms 10 also confirmed in her evidence that the findings of her audits were not shared with you. The NMC conceded that, given the time frame, the panel would be unlikely to conclude that you would have been in a position to escalate or act accordingly.

In light of this, the panel took the view that there was no evidence that you were aware of the concerns regarding care planning for skin integrity and therefore you cannot have had a duty to act or escalate these concerns. As such, it was satisfied that there was no evidence on which it could realistically find this charge proved.

Accordingly, it determined that there was no case to answer in respect of charge 1(b)(iii).

Charge 1(b)(iv): Inadequate care plans and/or failures to consistently create care plans in relation to risk of falls and/or mobility

The panel noted that the evidence in support of this charge came from the Root Cause Analysis report in relation to Patient C, produced in September 2013, and Ms 10's audits, conducted in the summer of 2014. In his submissions, Mr Collis argued that the

persistence of the issue suggested that you had failed to adequately escalate the problem / failed to take adequate action and therefore there remained a case to answer.

However, the panel also heard a wealth of evidence regarding the steps you, Registrant C and Registrant D took to escalate and address the issue of care planning, as set out in charge 1(b)(i). In 2012 you had already asked for additional support from the Trust to assist the Prison staff with care planning, but this support could not be provided. Colleague D, Nurse Consultant for Older People at the Trust, gave evidence that HMP Liverpool healthcare staff sought support from him in relation to older patients and that he developed a 'comprehensive geriatric assessment' for them to use. The panel also heard evidence of the considerable efforts you had made to escalate the staff shortages within the Prison (which Mr 8 had identified as one of the major contributing factors to the lack of care planning) and the difficulties you had in recruiting due to both nationwide issues and the Trust's Vacancy Control Panel process.

Once the Prison received additional support, improvements were seen. Mr 9 was allocated to the Prison in January 2014 and tasked with improving care planning by integrating and embedding MUST assessments, falls assessments and skin integrity assessments into the patient pathway at HMP Liverpool. At the same time, a long-term conditions nurse was finally appointed who prioritised the backlog of outpatient care plans. Work was also undertaken by Registrant C and Ms 26 to make System One more user-friendly. This included making the care plan templates easier to find and making risk assessments mandatory.

Ms 10 confirmed that she was aware of these ongoing projects and felt positive about them. In her view, they were appropriate steps to take in response to the concerns identified and she left the Prison in 2014 feeling very positive. All of the relevant witnesses agreed that you, Registrant C and Registrant D were working extremely hard to improve the situation at the Prison and doing everything that you could.

In light of the above, the panel determined that while there was evidence of concerns in the Prison in relation to care planning for the risk of falls and/or mobility, there was also an abundance of evidence of the considerable efforts that you and the rest of the health care team made to escalate and address these issues, and to mitigate the risks as far as you were able to without the provision of additional support. There was also evidence that, once you had received elements of the support which you had been asking for, significant improvements were achieved. The panel did not accept the submission put forward by the NMC, that repetition of the problem identified by Ms 10 in 2014 necessarily meant that the actions you had taken were inadequate. It considered that the evidence before it suggested that you had taken all the steps you could to escalate and address the issues within the Prison in relation to care planning for the risk of falls and/or mobility. The evidence suggested that the problems persisted until 2014 largely due to a lack of resources (which was outside of your control) and, once these resources were provided at the beginning of 2014, improvements were seen.

The panel also heard evidence and saw a CQC inspection report dated December 2014, which was after your departure from the Prison. This report highlighted the same concerns and in fact showed that standards had deteriorated significantly since the previous inspection in March 2014 when all standards were met for the Prison's health suite. The panel considered that this further undermined the submission that repetition of the concern was because of inadequate action or escalation on your part. The panel also noted that the NMC had provided no evidence of what, in its view, would have amounted to adequate escalation or adequate action. The panel therefore had no satisfactory evidence that your escalation or actions in respect of care planning for the risk of falls and/or mobility in the Prison were inadequate.

Accordingly, it determined that there was no case to answer in respect of charge 1(b)(iv).

Charge 1(c)(i): Inadequate risk assessments and/or failure to consistently conduct risk assessments in relation to long term health conditions

The panel had regard to the NMC's evidence matrix and noted that it sought to rely on the same evidence for this charge as it did for charge 1(b)(i), which concerned inadequate care planning for long-term health conditions. This evidence is set out in detail above at charge 1(b)(i). The NMC acknowledged the evidential difficulties it faced in relation to this charge, which was the same as those set out in charge 1(b)(i).

The panel took the view, from the evidence it had heard, that risk assessments formed one specific part of the overall care planning for a patient. Therefore, having found that there is no case to answer in relation to care planning for long-term health conditions (charge 1(b)(i)), it followed that there was no case to answer in relation to risk assessments for long-term health conditions, for the reasons given in charge 1(b)(i).

Accordingly, the panel determined that there was no case to answer in respect of charge 1(c)(i).

Charge 1(c)(ii): Inadequate risk assessments and/or failure to consistently conduct risk assessments in relation to weight management

The panel had regard to the NMC's evidence matrix and noted that it sought to rely on the same evidence for this charge as it did for charge 1(b)(ii), which concerned inadequate care planning in relation to weight management. This evidence is set out in detail above at charge 1(b)(ii).

The panel took the view, from the evidence it had heard, that risk assessments formed one specific part of the overall care planning for a patient. Therefore, having found that there is no case to answer in respect care planning in relation to weight management (charge 1(b)(ii)), it followed that there was no case to answer in respect of risk assessments in relation to weight management, for the reasons given in charge 1(b)(ii).

Accordingly, the panel determined that there was no case to answer in respect of charge 1(c)(ii).

Charge 1(c)(iii): Inadequate risk assessments and/or failure to consistently conduct risk assessments in relation to skin integrity

The panel had regard to the NMC's evidence matrix and noted that it sought to rely on the same evidence for this charge as it did for charge 1(b)(iii), which concerned inadequate care planning in relation to skin integrity. This evidence is set out in detail above at charge 1(b)(iii).

The panel took the view, from the evidence it had heard, that risk assessments formed one specific part of the overall care planning for a patient. Therefore, having found that there is no case to answer in respect of care planning in relation to skin integrity (charge 1(b)(iii)), it followed that there was no case to answer in respect of risk assessments in relation to skin integrity, for the reasons given in charge 1(b)(iii).

Accordingly, the panel determined that there was no case to answer in respect of charge 1(c)(iii).

Charge 1(c)(iv): Inadequate risk assessments and/or failure to consistently conduct risk assessments in relation to risk of falls and/or mobility

The panel had regard to the NMC's evidence matrix and noted that it sought to rely on the same evidence for this charge as it did for charge 1(b)(iv), which concerned inadequate care planning in relation to the risk of falls and/or mobility. This evidence is set out in detail above at charge 1(b)(iv).

The panel took the view, from the evidence it had heard, that risk assessments formed one specific part of the overall care planning for a patient. Therefore, having found that there is no case to answer in respect of care planning in relation to the risk of falls

and/or mobility (charge 1(b)(iv)), it followed that there was no case to answer in respect of risk assessments in relation to the risk of falls and/or mobility, for the reasons given in charge 1(b)(iv).

Accordingly, the panel determined that there was no case to answer in respect of charge 1(c)(iv).

Charge 1(c)(v): Inadequate risk assessments and/or failure to consistently conduct risk assessments in relation to requirements for restraints during external hospital visits

In relation to this charge the panel heard consistent and unchallenged evidence that the risk assessments for restraints during external hospital visits fell under the remit of the Prison's security staff and was outside the control of you or any of the other healthcare staff at HMP Liverpool. Ms 6 gave evidence that the risk assessments would be carried out by the Prison's security staff. Although the healthcare staff may be asked to provide information regarding the prisoner's health as part of that risk assessment, Ms 6 gave evidence that, in her experience the prison officers would make a decision regarding the requirement for restraint, regardless of the information provided by the healthcare team.

In light of this, the panel had no evidence that your responsibilities included ensuring that risk assessments were done. There was therefore no realistic prospect of it finding that you had a duty to escalate or take action in respect of inadequate risk assessments in relation to requirements for restraints during external hospital visits. Furthermore the panel also noted that the NMC conceded that this charge should not proceed.

Accordingly, the panel determined that there was no case to answer in relation to charge 1(c)(v).

Charge 1(d): Reports of inadequate patient record keeping

The panel noted that it had not been provided with any examples of patient records from the Prison. However, it acknowledged that poor record keeping was cited in a number of reports and inspections, including:

- Ms 2's PPO report into the DIC of Patient B, September 2012
- Ms 11's RCA report in relation to Patient C, September 2013
- Mr 1's PPO report into the DIC of Patient A, October 2013
- CQC inspection report, October 2013
- Ms 7's PPO Clinical Review for Patient D, December 2013
- Ms 10's audit of the Prison, January 2014 and July – August 2014
- Mr 1's PPO report into the DIC of Patient C, February 2014
- Colleague A's audit of the PPO reports, May 2014

Mr 9 and Ms 6 also gave evidence that they noted problems with record keeping during their time at the Prison (January – August 2014 and August – November 2014, respectively).

However, the panel also heard a wealth of evidence of the steps you, Registrant C and Registrant D were taking to escalate and address this problem. The panel heard evidence that there were two record keeping systems in use at the Prison: System One and EMIS. The charge does not specify which system, or both, is alleged to have been inadequate. However, it heard evidence that EMIS was only accessible by the LCH GPs and the Mersey Care mental health nurses working in the Prison. It was not used at all by the LCH nurses at the Prison. The panel was therefore satisfied that any criticisms of the record keeping on EMIS or a failure to adequately address these could not be attributed to you.

As regards SystemOne, the panel heard unchallenged evidence from a number of witnesses that SystemOne was not a user friendly system. Registrant C was involved in an ongoing project with a member of the Trust's IT team to overhaul SystemOne, make

it more user friendly, and improve its functionality in relation to record keeping within the Prison.

The panel also heard evidence from witnesses, specifically Mr 4 and Colleague A, about the impact of short staffing on record keeping. Nurses at the Prison were 'spread too thinly' and were therefore forced to prioritise more urgent aspects of care, at the expense of record keeping. The panel heard evidence about the nationwide difficulties in recruiting and retaining nurses in prisons, as well as the unique difficulties at HMP Liverpool due to focus on reducing staff numbers in order to meet CIP targets. The panel had evidence, discussed above, of the steps you took to attempt to recruit staff and escalate the issue of staff shortages to your Divisional Manager, Mr 24, as well as higher up the governance structure at the Trust.

The panel also heard evidence from Mr 8 that, when prisoners were transferred outside of the Prison for healthcare appointments, they were accompanied only by prison security staff with no member of the Prison's healthcare team present. This meant that the discharge information given by the hospital was not always communicated back to the healthcare team at the Prison, and therefore not recorded in the patient's records. The panel heard evidence that steps were taken to address this issue; Registrant D created a proforma checklist for prison officers to complete when they accompanied prisoners to hospital, however these were not reliably completed/returned.

Mr 24 also confirmed in his evidence that the Prison healthcare team undertook record keeping audits twice a year and action plans were created in response, which were escalated within the Trust.

The panel had regard to this evidence. It was satisfied that there was evidence of concerns being raised regarding inadequate patient record keeping in the Prison. However, there was also evidence that you took action to address these concerns and/or escalate them.

The issue the panel therefore had to consider was whether there was sufficient evidence to establish that your actions had been inadequate. The panel had regard to Mr Collis' submissions. In these submissions, he argued that the fact that the problem of inadequate record keeping persisted into the summer of 2014 suggested that the action taken by you, Registrant C and Registrant D was inadequate.

The panel could not accept this line of logic. Taking account of the extensive and unchallenged evidence it had heard from numerous witnesses regarding the unique challenges of the prison environment and the number of external factors which impeded the healthcare team's ability to provide care to prisoners and keep proper records, it was not satisfied that evidence of repetition of a concern was necessarily evidence that the action taken to address that concern by you was in itself inadequate.

The panel heard evidence that you were reporting and escalating concerns and there were significant challenges facing healthcare delivery that were outside your control. The panel also heard evidence and saw a CQC inspection report dated December 2014, which was after your departure from the Prison. This report highlighted the same concerns and in fact showed that standards had deteriorated significantly since the previous inspection in March 2014 when all standards were met for the Prison's health suite. The panel considered that this further undermined the submission that repetition of the concern was because of inadequate action or escalation on your part.

Furthermore, the NMC had provided no evidence of what would have amounted to adequate escalation or adequate action in these circumstances. The panel therefore had no satisfactory evidence that your escalation or actions in respect of inadequate patient record keeping was inadequate.

Accordingly, it determined that there was no case to answer in respect of charge 1(d).

Charge 1(e): Reports of concerns in respect of medicines management and/or the administration of medication

The panel noted that the evidence in support of this charge came from a number of reports and audits. These included:

- Ms 6's PPO Clinical Review of Patient C, August 2013
- Mr 8's HMIP inspection report, October 2013
- Ms 13's review of the Prison, completed in March 2014
- Ms 10's audits, completed in the summer of 2014

The panel also heard evidence from Ms 6 that medication management and administration continued to be a problem when she was based at the Prison in August – November 2014.

However, the panel also heard evidence, elicited through cross-examination, that medicines management and administration had been a long-term concern at the Prison, which had grown more acute over time. Mr 8 gave oral evidence about the specific difficulties of managing and administering medicines in a prison environment. He told the panel that medicines administration took place three times a day for 45 minutes, sometimes less. The queues of prisoners waiting to receive their medications were not properly overseen by the prison officers and the environment could get very loud and disruptive. Prisoners were supposed to bring their ID cards to the pharmacy hatch but would often forget them or bring someone else's, which caused further delays and problems. Mr 8 gave evidence that these issues were not unique to HMP Liverpool.

The panel also heard evidence that the Prison did not have an onsite pharmacist or technician at the time of Mr 8's HMIP inspection which, in his opinion, contributed to the issues.

However the panel also heard evidence of the efforts you, Registrant C and Registrant D made to escalate and address these problems. Mr 24 confirmed in his oral evidence that the concerns regarding medicines management and administration in the Prison

had been escalated to him and were rated as a ‘red risk’ on the Trust’s risk register. The panel also heard evidence that additional support was provided to the Prison in the summer of 2012 by Dr 27 through a project to increase the use of ‘in possession’ medication for prisoners. The panel had evidence, in the form of emails, which showed that the Prison had sought additional help from the Trust’s Medicines Management team in April / May 2013, but they did not have the capacity or resources to assist. The panel also had evidence that you and Registrant D had escalated the problems caused by prison security to the Governor on a regular basis. Following the publication of the CQC’s 2013 inspection report, an action plan was formulated in December 2013 to address the problems associated with medicines management and administration within the Prison. When the CQC inspected the Prison again in March 2014 there was a noted improvement in medicines management. The panel also heard evidence that by early 2014 there was a project underway to introduce a pharmacy into the Prison which resulted in the recruitment of both a pharmacist and a technician.

The panel was satisfied that there was evidence of concerns being raised regarding medicines management and administration in the Prison. However, there was also evidence that you took action to address these concerns, which resulted in the improvement noted by the CQC in March 2014.

The issue the panel therefore had to consider was whether there was sufficient evidence to establish that you had failed to adequately escalate and/or take adequate action. The panel had regard to Mr Collis’ submissions. In these submissions, he argued that Ms 10 still identified medicines management concerns in her audits conducted in the summer of 2014, and that this repetition suggested that the action taken by you, Registrant C and Registrant D was inadequate.

The panel could not accept this line of logic. Taking account of the extensive and unchallenged evidence it had heard from numerous witnesses regarding the unique challenges of the prison environment and the number of external factors which impeded the healthcare team’s ability to safely manage and administer medications in the Prison,

it was not satisfied that evidence of repetition of a concern was necessarily evidence that the action taken to address that concern by you was in itself inadequate.

The panel was unable to infer that because there was a repetition of a reported concern this was determinative of an inadequate response by you. The panel heard evidence that you were reporting and escalating concerns and there were significant challenges facing healthcare delivery that were outside your control. The panel also heard evidence and saw a CQC inspection report dated December 2014, which was after your departure from the Prison. This report highlighted the same concerns and in fact showed that standards had deteriorated significantly since the previous inspection in March 2014 when all standards were met for the Prison's health suite. The panel considered that this further undermined the submission that repetition of the concern was because of inadequate action or escalation on your part.

Furthermore, the NMC had provided no evidence of what would have amounted to adequate escalation or adequate action in these circumstances. The panel therefore had no satisfactory evidence that your escalation or actions in respect of medicines management and administration were inadequate.

Accordingly, it determined that there was no case to answer in respect of charge 1(e).

Charge 1(f): Reports of inadequate management of controlled drugs and/or the administration of controlled drugs

The panel noted that all of the evidence it had heard relating to this charge suggested that the first reports of inadequate management of controlled drugs and/or the administration of drugs at the Prison did not emerge until after you had been suspended in July 2014. It heard no evidence that any such concerns were raised with you while you were at the Prison, and therefore it cannot be said that you failed to act upon them. The panel was therefore satisfied that there was insufficient evidence to support this charge.

Accordingly, it determined that there was no case to answer in respect of charge 1(f).

Charge 1(g): Reports that supervised methadone was not being properly supervised or controlled

The panel heard evidence from a number of witnesses, including Ms 12, Ms 6 and Mr 24, that the provision of methadone services within the Prison was the responsibility of a different NHS Trust – Mersey Care. Mr 24 and Ms 12 both confirmed in their evidence that Mersey Care was entirely responsible for the provision of methadone within the Prison and you, as LCH staff, would not have been involved with this. There was no evidence to establish that you had a duty to ensure that methadone was being properly supervised or controlled, and therefore no evidence that you had a duty to take action or escalate this issue. The panel also noted that Mr Collis, in his submissions, acknowledged that there was no evidence to support this charge.

Accordingly, the panel determined that there was no case to answer in relation to charge 1(g).

Charge 1(h): Reports that health screening/assessments and/or secondary health checks for new and/or returning prisoners/patients were not being completed and/or were not being completed adequately

The panel heard unchallenged evidence that there were no concerns identified in relation to the initial health screening of prisoners at HMP Liverpool. 100% of new prisoners at HMP Liverpool received an initial health screen, as it was not possible for them to move from reception into the induction wing until this had been completed. The panel was therefore satisfied that there was no evidence to support the charge in relation to initial health screening assessments.

The panel did however hear evidence that there were concerns about the completion of secondary health assessments, which were required to be completed within 72 hours of the initial health screen. This was highlighted as a concern in the following reports:

- Mr 8's HMIP inspection report, October 2013
- Ms 25's CQC inspection report, October 2013
- Colleague A's audit of the PPO reports, May 2014

Ms 12 also gave evidence that the completion of secondary health assessments was a concern when she was working in the Prison in the summer of 2014.

However, the panel also heard evidence that the low rate of secondary health assessments was due to a variety of factors. Mr 8 told the panel in oral evidence that the completion of secondary screening was highly dependent on the cooperation and support of prison security staff. Furthermore, prisoners were not required to accept the offer of secondary health screening and would often prioritise other matters, such as bail applications, paid work engagements, and visits from their legal representatives and their families.

Mr 8 gave evidence that the importance of secondary screening needed to be communicated to prisoners while they were on the induction wing. However, the Governor at HMP Liverpool had removed the slot previously given to the healthcare team from the programme of presentations given to new prisoners. It was therefore difficult to get the message to prisoners that secondary screening was optional but nonetheless very important.

The panel also had evidence that the number of incoming prisoners doubled from 250 to 500 in September 2012. The 72 hour secondary screening target remained the same, but the healthcare team at the Prison was given no additional resources to cope with this increased demand, despite requests by you for additional staff and resources. The panel reminded itself of the unique staffing challenges faced by the Prison both as a result of the CIPs and the difficulty in recruitment and retention of staff into prison

healthcare generally. As a result, by July 2013 the secondary screening completion rate had decreased from 30% to 18%.

However, the panel also had evidence of the steps that you, Registrant C and Registrant D had taken to address these concerns. Mr 24 confirmed in evidence that the increased demand for secondary screening, and its corresponding low completion rate, had been escalated and raised as a red risk by you to the divisional risk register. Ms 6 gave evidence that, by the time she joined the Prison in August 2014, an entirely new system for secondary screening had been implemented and the healthcare team had been given back its slot in the induction timetable for prisoners.

Ms 12 also agreed that you and the other managers in the Prison had been proactive in trying to improve the secondary screening rate through various strategies. These included introducing new appointment slips and moving clinics into the induction wing itself. Ms 12 confirmed that these strategies did result in progress over time.

The work being undertaken was noted by Ms 25 when she conducted the second CQC inspection in March 2014. She reported that appropriate steps had been taken and 'despite these matters being out (of) the Trusts control we found that since our last inspection nursing staff had been both creative and proactive in their attempts to get prisoners to their healthcare appointments'.

The panel had regard to this evidence. It was satisfied that there was evidence of reported concerns in relation to the non-completion of secondary health screening assessments at the Prison. However, there was also evidence that you took action to address these concerns, which resulted in improvement.

The issue the panel therefore had to consider was whether there was sufficient evidence to establish that your action had been inadequate. The panel had regard to Mr Collis' submissions. In these submissions, he argued that Ms 12 identified this problem when she visited the Prison in the summer of 2014, and therefore the repetition of this

concern suggested that the action taken by you, Registrant C and Registrant D was inadequate.

As discussed in previous charges, the panel did not accept this submission. Taking account of the evidence it had heard from numerous witnesses regarding the unique challenges of the prison environment and the number of external factors which impeded the healthcare team's ability to meet the secondary screening targets, it was not satisfied that evidence of repetition of the issue was necessarily evidence that the action taken to address that issue by you was in itself inadequate.

The panel was unable to infer that because there was a repetition of a reported concern this was determinative of an inadequate response by you. The panel heard evidence that you were reporting and escalating concerns and there were significant challenges facing healthcare delivery that were outside your control. The panel also heard evidence and saw a CQC inspection report dated December 2014, which was after your departure from the Prison. This report highlighted the same concerns and in fact showed that standards had deteriorated significantly since the previous inspection in March 2014 when all standards were met for the Prison's health suite. The panel considered that this further undermined the submission that repetition of the concern was because of inadequate action or escalation on your part.

Furthermore, the NMC had provided no evidence of what would have amounted to adequate escalation or adequate action. The panel therefore had no satisfactory evidence that your escalation or actions in respect of secondary screening at the Prison were inadequate.

Accordingly, it determined that there was no case to answer in respect of charge 1(h).

Charge 1(i): Reports of insufficient staffing levels within the prison and/or lack of training opportunities for staff

The panel heard evidence from numerous witnesses that staffing levels within the Prison were a persistent problem, which had a significant impact on the ability of you, Registrant C and Registrant D to provide care to patients. The panel also had evidence that you repeatedly escalated this issue to your Divisional Manager, Mr 24, and further up into the Trust's governance structure.

The panel heard evidence of the nationwide difficulty in recruiting and retaining healthcare staff to work in Prisons. It also heard considerable evidence of the specific challenges of recruiting to HMP Liverpool. Many witnesses gave oral evidence regarding the Trust's implementation of Cost Improvement Plans ("CIPs") and the impact this had on staff recruitment. In relation to the Prison, Mr 24, confirmed in his oral evidence that:

i. There was a 'top down' pressure to prioritise financial savings over clinical issues. The main focus of the Trust at the time was to achieve the CIPs in order to obtain Foundation Trust status. His division (which included the Prison) had a target of 20% cost savings over 12 months which he described as "impossible". He told the panel that, in his experience working in the NHS for 30 years, 4% is generally accepted as the safe and effective maximum annual saving.
ii. The CIPs were first developed in 2011. The Prison proposed reducing costs by reducing the number of permanently employed GPs and relying instead on locum and agency GPs on an ad hoc basis. This was supported by a Quality Impact Assessment ("QIA") which was approved and signed off by him.
iii. The workforce at HMP Liverpool and HMP Kennett were combined in April 2012. The two managers at HMP Kennet were made redundant, leaving you, Registrant C and Registrant D as the only managers across both sites. This aspect of the CIP was imposed from higher up the Trust's governance structure and no additional QIA was carried out to reflect this amendment.

iv. In 2012 the Trust contracted a consultant to advise on the progression of the CIPs. He recommended the establishment of the Project Management Office ("PMO") which in turn devised the 20% CIP target for Mr 24's division.

v. One of the key methods for delivering this new target was the deletion of £10.3 million of budget lines for vacancies. This second phase of the CIPs came into effect in mid-2012.

vi. Mr 24 was performance managed for the delivery of the CIP for the division, so if one was not manageable then it was redistributed across his other services. The Prison ended up having to absorb a much higher share of the cost savings than originally planned (potentially up to 25% of the budget), due to other services within the division not being able to meet their targets.

vii. Over time, Mr 24 had to add more and more to the Prison's CIP as his other services struggled to meet their targets. Increasing numbers of budget lines had to be deleted, particularly in relation to vacancies.

viii. You, Registrant C and Registrant D were given no choice or control in relation to the CIPs and you, in particular, were a vocal opponent to the cost cuts. You voiced your concerns at divisional meetings, via email, and even attended the Trust's Health Care Governance Sub Committee meeting to express your concerns about the effect of the CIPs on patient safety and staff wellbeing.

ix. As a result of the CIP programme a Vacancy Control Panel ("VCP") was established in or around May 2012. All requests for additional/replacement staff had to go via the VCP and the VCP would delay and refuse recruitment requests as a technique to delay budget lines. Vacancy control was a key tool in delivering CIPs and the majority of requests were refused.

x. After the CQC report was published in 2013 the pressure on Mr 24 to reduce the workforce decreased, but there were still issues with Capita (an external professional services company used by the Trust for recruitment) which caused significant delays to recruitment, such as security checks for successful candidates.

The panel also had evidence that you, Registrant C and Registrant D were repeatedly reporting your concerns about insufficient staffing levels and requesting additional support. This included:

i. An email sent by Registrant C to you and Mr 24 on 24 March 2013 in which she expresses concerns about the lack of leadership in the Prison as it has been without any band 7 managers for over a year, compounded by long absences from the senior managers due to secondments. In this email she states that she 'has been running with a team that has over 50% non-effectives' (due to sickness, secondments and suspensions) and is 'surprised that we have continued the basic core business'.

ii. Emails between you, Registrant C and Mr 24 chasing the outcome of recruitment paperwork sent to the VCP. Mr 24 confirmed in his oral evidence that there was a problem with recruitment paperwork going missing after it was sent from the Prison; either there would be nothing there or he would approve it and it would go missing in the system.

iii. A 'deep dive' report prepared by you on 9 September 2013. This report outlines a lack of permanent GPs, high levels of staff sickness, problems with retention of experienced staff and the potential deterioration of patient care as a result. In his oral evidence Mr 24 accepted that he was aware of the report and the issues were escalated to him but he was unable to do anything as he "had no money".

iv. An email from Registrant D to Mr 24 on 11 October 2013 escalating the pressure on the Prison, including staff shortages.

v. An email from you to Dr 20 and Mr 24 on 4 June 2014 confirming that you had 7 vacancies, 6 staff off sick and that you personally had not had a day off in two weeks.

The panel also had evidence that you were trying to come up with 'cost neutral' solutions by reallocating staff, proposing skill mix reviews and identifying new recruitment opportunities.

Colleague A gave evidence that low staffing numbers inevitably had an effect on training; if there were not enough nurses to cover the shift then it was not possible to free some of them up to attend training. Despite this, Mr 8 confirmed that at the time of his HMIP inspection all mandatory training was up to date.

The panel had no doubt that there was evidence of reports of insufficient staffing levels within the Prison. However, there was also evidence that you, Registrant C and Registrant D took action to address and escalate this issue.

The issue the panel therefore had to consider was whether there was sufficient evidence to establish that you had failed to adequately escalate or take adequate action in respect of these issues. The panel had regard to Mr Collis' submissions. In these submissions he argued that, notwithstanding your efforts, the problem of insufficient staffing remained when the Prison was visited by Ms 12 in the summer of 2014 and therefore the persistence of this issue suggested that the action taken by you, Registrant C and Registrant D was inadequate.

The panel did not accept this submission. Taking account of the extensive and unchallenged evidence it had heard from numerous witnesses regarding the unique challenges of recruiting and retaining staff within the Prison, together with the Trust's focus on prioritising cost savings through limiting recruitment, all of which was outside of your control, it was not satisfied that the persistent problem of inadequate staffing was necessarily evidence that the action taken to address that concern by you was in itself inadequate.

The panel was unable to infer that because there was a repetition of a reported concern this was determinative of an inadequate response by you. The panel heard evidence that you were reporting and escalating concerns and there were significant challenges facing healthcare delivery that were outside your control. The panel also heard evidence and saw a CQC inspection report dated December 2014, which was after your departure from the Prison. This report highlighted the same concerns and in fact

showed that standards had deteriorated significantly since the previous inspection in March 2014 when all standards were met for the Prison's health suite. The panel considered that this further undermined the submission that repetition of the concern was because of inadequate action or escalation on your part.

Furthermore, the NMC had provided no evidence of what would have amounted to adequate escalation or adequate action in these circumstances. The panel therefore had no satisfactory evidence that your escalation or actions in respect of insufficient staffing levels at the Prison were inadequate.

Accordingly, it determined that there was no case to answer in respect of charge 1(i).

Charge 2: Failed to ensure Trust level investigations were conducted into the Deaths in Custody of Patient A, Patient B, Patient C and Patient D

The panel was not provided with any Trust policies regarding Trust level investigations and Deaths in Custody ("DIC"). The panel had sight of a national policy, dated 2015, but was not provided with the earlier version of the national policy on which the local Trust policy ought to have been based. A number of witnesses gave differing recollections of what they understood the Trust policy to be. Dr 20**,** the Trust's Medical Director, recalled that in his view the Trust policy regarding DICs was to defer to the statutory investigation process and allow DICs to be investigated fully by the PPO and/or the Coroner. He rejected the suggestion that any internal Trust investigation was required.

Several other witnesses gave evidence in relation to the Trust's policy but none could remember the contents of the policy with any certainty. All of them speculated based on their experience at other trusts, or what they would expect to be the case. Their evidence was wholly inconsistent.

Ms 12, confirmed in her evidence that for every DIC she would expect a Trust level investigation to be completed. She also confirmed that the decision to commission such

a report would be taken higher up within LCH's governance team. Ms 12 also confirmed that every DIC was appropriately escalated out of the prison within 72 hours. Mr 24 also confirmed that the decision regarding further investigation would be taken by the LCH Board.

Without any documented policy or procedure to assist it, or any consistency in witnesses' recollection of the process, the panel was presented with a number of differing recollections and assumptions as to how DICs were supposed to be investigated by the Trust. There was no evidence before the panel that you were required to ensure Trust level investigations were conducted or that you did not appropriately escalate DICs. Looking at this evidence as a whole, the panel was not satisfied that the evidence was reliable enough to enable it to find this charge proved.

Furthermore, in his submissions, Mr Collis acknowledged that there was insufficient evidence for the panel to properly conclude that you were under a duty to conduct Trust level investigations and/or Serious Untoward Incident reports in relation to DICs.

Accordingly, the panel determined that there was no case to answer in relation to charge 2 in its entirety.

Charge 3: Failed to ensure that Serious Untoward Incident reports were conducted following the Deaths in Custody of Patient A, Patient B, Patient C and Patient D

The panel determined that there was no case to answer in relation to this charge, for the same reasons given for charge 2. The panel was not provided with a written policy outlining the investigative process following a death in custody, and the evidence of the witnesses was inconsistent and largely speculative. Looking at this evidence as a whole, the panel was not satisfied that the evidence was reliable enough to enable it to find this charge proved.

Furthermore, in his submissions, Mr Collis acknowledged that there was insufficient evidence for the panel to properly conclude that you were under a duty to conduct Trust level investigations and/or Serious Untoward Incident reports in relation to DICs.

Accordingly, the panel determined that there was no case to answer in relation to charge 3 in its entirety.

Charge 4: Discouraged staff from reporting adverse incidents and/or submitting Datix reports on one or more occasions

When the NMC opened its case, the panel was informed that the evidence in support of this charge had been deemed inadmissible at a preliminary meeting. The panel heard no other evidence which supported this charge. It therefore determined that there was no case to answer in relation to charge 4.

Having found that there is no case to answer in relation to all of the charges, your case will progress no further.

The panel's determination will not be published on the NMC's website. If you would like the NMC to publish the panel's determination you must contact your NMC case officer to arrange for this to be done.

The panel's determination will be confirmed to you in writing.

That concludes this hearing.