Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
17 – 25 May 2021

Resuming Substantive Hearing
1-3 September 2021

Temple Court
13a Cathedral Road, Cardiff, CF11 9HA

Name of registrant:	Mrs Valsamma Kunnapallil Tomy
NMC PIN:	06F0231O
Part of the register:	Registered Nurse Adult – June 2006
Area of registered address:	Bristol
Type of case:	Lack of competence/Misconduct
Panel members:	Paul Powici (Chair, lay member) Carla Hartnell (Registrant member) Alice Rickard (Lay member)
Legal Assessor:	Charles Parsley
Panel Secretary:	Leigham Malcolm [17-25 May 2021] Vicky Green [1-3 September 2021]
Nursing and Midwifery Council:	Represented by Mr Dominic Evans, Case Presenter instructed by the NMC
Mrs Tomy:	Present and unrepresented
Facts proved by admission:	Charges 1i & 4
No case to answer:	1a, b, d, e, f, g, h, 5a, b, c, & 6
Facts proved:	1c, j, 2 & 3
Fitness to practise:	Impaired by way of lack of competence

Sanction:	Conditions of practice order – 12 months (with a review)
Interim order:	Interim conditions of practice order – 18 months

Details of charge

That you, whilst employed by University Hospitals Bristol NHS Trust, as a registered nurse, Band 5, between 20 October 2017 and 8 February 2019:

1) Were not able to demonstrate the standards of knowledge skill and judgement required to practice in that you:

a) On 21 October 2017, tipped more than one medication into the mouth of patient BF. ***[No case to answer]***

b) On 21 October 2017, did not record that patient BF had refused to take his medication or that medication had not been administered. ***[No case to answer]***

c) On 21 October 2017, having been informed that patient BF had abdominal pain and/or suffering from the retention of fluids by a nursing assistant did not take action to reduce the fluids in patient BF's bladder. ***[Proved]***

d) On 21 October 2017, performed a bladder scan on patient BF using an incorrect technique, namely, by incorrectly moving the scanner up and down on patient BF's abdomen. ***[No case to answer]***

e) On 21 October 2017, having received a bladder scan reading of 437 millilitres did not take account of the previous bladder scan reading of 417 millilitres and catheterise patient BF. ***[No case to answer]***

f) On 21 October 2017, did not document the results of the bladder scan reading in patient BF records, namely the reading taken of around 437 millilitres.

g) *On 14 December 2017 did not explain the cannula process to patient CF prior to inserting a cannula.* ***[No case to answer]***

h) *On 2 July 2018 inserted a cannula into patient W's arm without obtaining consent to perform the procedure from the patient.* ***[No case to answer]***

i) *On or before 5 April 2018 incorrectly identified the responsible consultant team when requesting a blood sample.* ***[Proved by way of admission]***

j) *On the 3 July 2018 did not carry out safe and effective medicines management, in that you signed for medication which you had not administered in the morning to (female) patient X.* ***[Proved]***

2) *On 20 December 2017 signed a medication record to indicate that you had administered Enoxaparin (Clexane) when you had not administered the said medication at the time of signing the medication record. MS* ***[Proved]***

3) *On or around 20 December 2017 administered a dose of Enoxaparin when you were uncertain as to whether you had already administered a dose of Enoxaparin in the preceding 24 hours to the same patient. MS* ***[Proved]***

4) *On 28 March 2018 did not administer prescribed Heparin (an anti-coagulant injection) to patient AO.* ***[Proved by way of admission]***

5) *On 1July 2018 failed to treat patient T appropriately in that you:*

a) *Removed a continence pad without any communication or explanation of your actions;* ***[No case to answer]***

b) *Did not obtain consent from the patient to remove a continence pad;* ***[No case to answer]***

c) *Removed the said continence pad without providing the patient adequate privacy by leaving the curtains near to the patient open and/or the patient exposed.* ***[No case to answer]***

6) *On 3 July 2018 failed to follow the correct manual handling practice, namely by pulling patient W by their shoulder without the assistance of another member of staff.* ***[No case to answer]***

AND in light of the above, your fitness to practice is impaired by reason of your lack of competence in relation to one or more of the charges from charge 1 to 4 and/or by reason of your misconduct in relation to one or more of the charges from charge 5 to 6.

Preliminaries

You are a member of UNISON, who had instructed Thompsons solicitors to represent you in these regulatory proceedings, as they had done earlier in this case. At some point there appears to have been a misunderstanding as a result of which you mistook your NMC case officer for the solicitor you believed had been instructed. It appears that you therefore stopped communicating with Thompsons and/or UNISON. In March 2021 Thompsons advised the NMC that they were no longer representing you. You attended the hearing on day one expecting, mistakenly, that you would be represented by your union/these solicitors.

After unsuccessful attempts to contact UNISON throughout day one and into day two of the hearing, via telephone and email, the panel considered the following courses of action:

- To adjourn, to an alternative later date, to enable you to secure representation, or;
- Proceed with the hearing without representation.

Mr Evans on behalf of the Nursing and Midwifery Council (NMC) submitted that the hearing ought to proceed with you unrepresented.

You told the panel that you did not know if or when you would be able to get a reply from Unison or Thompsons about the possibility of their representing you at this hearing.

The panel noted that:

- You were provided with notice of this hearing in mid-April 2021;
- There is no reason to suppose that by adjourning you would be able to secure representation for a hearing at some future date given the lack of contact with UNISON during days one and two of the hearing;
- Three witnesses have been organised to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

For these reasons the panel decided to proceed with the hearing as scheduled. You did not object to this.

Subsequent to the panel's decision, you received a reply via email from UNISON which concluded:

> *"UNISON is no longer able to assist with this matter."*

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Evans under Rule 31(1) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) to admit into evidence the written witness and other statements of Ms 5 and Mr 4 and statements from Ms 6, from whom there was no witness statement.

Mr Evans referred the panel to the cases of Thorneycroft v NMC [2014] EWHC 1565 (Admin), Ward v NMC [2014] EWHC 1158 (Admin) and Njie v NMC [2014] EWHC 1279 (Admin). He referred the panel, in particular, to the guidance set out in the case of Thorneycroft, set out at paras 45 and para 56, for admitting into evidence the statements of witnesses, despite their absence:

> *"56. The decision to admit the witness statements despite their absence required the Panel to perform careful balancing exercise. In my judgment, it was essential in the context of the present case for the Panel to take the following matters into account:*
>
> > *(i) whether the statements were the sole or decisive evidence in support of the charges;*
> > *(ii) the nature and extent of the challenge to the contents of the statements;*
> > *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> > *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
> > *(v) whether there was a good reason for the non-attendance of the witnesses;*
> > *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
> > *(vi) the fact that the Appellant did not have prior notice that the witness statements were to be read."*

Mr Evans informed the panel that Ms 5 is not present at this hearing and, whilst the NMC had made attempts to secure her presence, she is unable to attend in person, or by other means, as she is believed to be travelling around Australia. He submitted that Ms 5's witness statement is highly relevant and invited the panel to admit it into evidence. He further submitted that it had always been the intention of the NMC for this witness' evidence to be read and your then solicitor had not objected to this.

Mr Evans then informed the panel that although it is believed he may be in Italy the whereabouts of Mr 4 is unknown to the NMC. He produced a record of a telephone conversation between the NMC and Mr 4 on 28 January 2020 during which Mr 4 stated that he would no longer be assisting the NMC. Mr Evans highlighted that Mr 4 worked as a health care assistant and therefore the NMC were unable to compel him to cooperate in proceedings. He submitted that Mr 4's witness statement is highly relevant and invited the panel to admit it into evidence.

Mr Evans next informed the panel that Ms 6 was not present at this hearing and, whilst the NMC had made efforts to obtain a witness statement from her their attempts to contact her had been unsuccessful. The NMC had not attempted to contact her since April 2020. Mr Evans highlighted that as Ms 6 worked as a health care assistant, the NMC were also unable to compel her to cooperate in proceedings. He nevertheless submitted that the evidence of Ms 6 was highly relevant and invited the panel to admit it into evidence, despite there being no witness statement from her.

He further submitted that if the statements were admitted then the panel could determine the weight to be given to them at a later stage of its deliberations.

In addition, Mr Evans applied to admit the investigation report and appendices, in particular the investigating officer's interviews with other members of staff, into evidence. The panel questioned why not only was the Trust's investigating officer, who made the referral to the NMC, not attending as a witness, but why there was no witness statement

from him. The panel raised this question also in view of the fact that in the notice of hearing bundle there was included, apparently inadvertently, a letter addressed to him at the Trust raising the question of his possible attendance as a witness.

You did not make any submissions in response to the Rule 31 application made by Mr Evans.

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 reference to the provision in Rule 31 that the discretion to admit evidence in a range of forms, whether or not it is admissible in civil proceedings, is ... 'subject only to the requirements of relevance and fairness.', and that it should consider the guidance referred to in the authorities provided by Mr Evans.

The panel was mindful that the question of the weight which it should attribute to hearsay evidence would only arise if the panel decided that it was fair to admit such evidence.

The panel first considered the statement made by Ms 5 which exhibits two Datix reports. The panel noted that you had in the past been given prior notice that the statement made by Ms 5 would be read, and that there had apparently been no objection to this by your representative at that time. While it may be the only direct evidence in relation to Charges 2 and 3, the panel considered that the sole purpose of the statement by Ms 5 was to exhibit documentary evidence. The panel detected no indication of underlying tensions between Ms 5 and you. Although Ms 5 could theoretically give evidence via video link or telephone from Australia, the panel accepted that as she was said to be travelling around it may be difficult for her to join remotely. Ms 5's statement made it clear that she could not remember the incidents in any more detail than what is written in the Datix reports.

The panel decided, in the circumstances, to allow the application in relation to the statement by Ms 5 and all other related documentary evidence. The panel determined to decide on what weight to attach to the statement by Ms 5 at a later time.

The panel then considered the witness statement of Mr 4. The panel bore in mind that Mr 4 was believed to be in Italy, although there was no information to confirm his whereabouts. It also bore in mind the unsuccessful efforts made by the NMC to engage Mr 4 and his response, in particular that 'he does not wish to attend a hearing'.

With regard to the guidance set out in the case of Thorneycroft, in the panel's assessment Mr 4's witness statement is the sole or decisive evidence in support of charges 1a, b, c, d, e, & f. You have denied these charges. The panel also considered, however, that there was some indication that because there may have been underlying tensions between Mr 4 and you, that may give rise to concern as to the reliability of the allegations he makes. In his absence, neither the panel nor you would be able to test his evidence or ensure that the allegations are well-founded.

Further, the panel noted the seriousness of the charges. The panel found that no good reason was given for Mr 4 not attending, he simply he made it clear that he was unwilling to do so. Also, you have not been provided with prior notice that the witness statement was to be read; he appears in the list of witnesses to be called. In these circumstances, the panel decided to refuse the application in relation to the witness statement of Mr 4 and all other related documentary evidence, as to admit it would be unfair.

The panel then considered the allegations Ms 6 made to the Trust. It noted that no witness statement had ever been made by her. With regard to the guidance set out in the case of Thorneycroft, the panel decided that this information was the sole or decisive evidence in support of Charges 1h, j, 5a, b, c, & 6. Again, you have denied these charges. The panel also considered, however, that there was some indication that because there may have been underlying tensions between Ms 6 and you, that may give rise to concern as to the reliability of the allegations she makes.

Further, the panel noted the seriousness of the charges. The panel found that no good reason was given for her non-attendance. The panel was informed that there had been no attempts by the NMC to contact Ms 6 since April 2020. In these circumstances, the panel

decided to refuse the application to admit any evidence of Ms 6, as to admit it would be unfair.

Looking then to the investigation report and appendices, the panel noted, as confirmed by the evidence of Ms 2, that there was no evidence except in the case of Ms 7 that any of the investigating officer's notes had even been sent to the interviewees. Nor had any of the other notes been returned with comments as to their accuracy, despite the fact that each of these interviews was introduced by a statement that a verbatim record was not being made and that the interviewee would be given the opportunity to confirm the notes taken.

While noting that it would still have been hearsay, the panel was not given any explanation why the investigating officer did not attend even to seek to confirm what he had been told by respective staff members who were themselves not providing witness evidence.

Whilst there was no direct suggestion that the witnesses had reason to fabricate their allegations, there was a suggestion that relations between you and other members of staff, in particular health care assistants, were strained. Further, the evidence of Ms 1 was that although she had been asked to act as a mentor to you, she had been instructed not to initiate any contact with you in that role, but only respond if you approached her. This suggested that there could be underlying tensions.

Except for the records of your interviews, where you will have an opportunity to comment on their accuracy, the panel decided not to admit the investigation report and appendices, as it would be unfair to do so for the reasons stated and, particularly, given its concerns around their reliability.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Evans to amend the wording of charge 6 pursuant to Rule 28 of the Rules:

> *"28.(1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11) the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) [or the Fitness to Practise]146 Committee, may amend*
>
> *(a) the charge set out in the notice of hearing; or*
>
> *(b) the facts set out in the charge, on which the allegation is based, unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> *(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue."*

Charge 6:

6) *On 3 July 2018 failed to follow the correct manual handling practice, namely by pulling patient W by their shoulder without the assistance of another member of staff*

Proposed amendment:

6) *On **2** July 2018 failed to follow the correct manual handling practice, namely by pulling **a patient under** their **arm** without the assistance of another member of staff*

The effect of the proposed amendment would be to change the date of the alleged conduct, to replace the reference to patient W with an unspecified patient, as well as to change the conduct alleged. It was submitted by Mr Evans that the proposed amendment would more accurately reflect the evidence before the panel.

You did not make any submissions in response to the Rule 28 application made by Mr Evans.

The panel accepted the advice of the legal assessor.

In considering whether or not to accept Mr Evan's application to amend Charge 6 the panel took account of the witness statement of Ms 3. The witness statement of Ms 3 refers to one incident on 2 July 2018. Whilst Ms 6 refers to two manual handling incidents, one on 2 July 2018 and one on 3 July 2018, the panel had excluded the evidence as inadmissible for the reasons already set out. The panel was satisfied that Charge 6 related to an incident that is alleged to have occurred on 3 July 2018, in relation to which there is no admissible evidence. Ms 3 confirmed to the panel that the only shift she worked was on 2 July 2018. The incident on 2 July 2018 appears to relate to a separate incident, which has never been the subject of a charge. To allow the proposed amendment would have the effect of creating an entirely new charge.

The panel was not satisfied, particularly when you are not represented, that the proposed amendment would not cause prejudice to you or that no injustice would be caused by the proposed amendment being allowed. The panel therefore determined that, at this stage in proceedings, it was not in the interests of justice to allow the amendment, which would effectively create an entirely new charge.

Decision and reasons on no case to answer

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

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

Of its own volition, the panel invited submissions from Mr Evans as to whether sufficient evidence had been presented to find the facts of the disputed charges proved. The panel heard the submissions of Mr Evans as to the evidence in support of each charge. You did not make any submissions on the matter.

The panel accepted the advice of the legal assessor which included reference to R v Galbraith [1981] 1 WLR 1039.

The panel noted its earlier decision not to admit into evidence the written witness and other statements of Mr 4 or statements from Ms 6, as well as its decision not to amend Charge 6. In respect of each charge, the panel considered whether there was any evidence to support the charge, or whether there was some evidence but it was of such a tenuous character that taken at its highest it could not say that the NMC had satisfied it to the requisite standard that there was a case to answer.

Charge 1a:

1) *Were not able to demonstrate the standards of knowledge skill and judgement required to practice in that you:*

a) *On 21 October 2017, tipped more than one medication into the mouth of patient BF.*

The panel first considered Charge 1a. The panel was of the view that, taking account of the admissible evidence before it, it could not find the facts of charge 1a proved. The panel noted that you denied this allegation. Having excluded Mr 4's statement the panel decided that there is no evidence to support Charge 1a.

Charge 1b:

b) *On 21 October 2017, did not record that patient BF had refused to take his medication or that medication had not been administered.*

The panel next considered Charge 1b. The panel was of the view that, taking account of the admissible evidence before it, it could not find the facts of charge 1b proved. The panel noted that the only evidence that could have supported this charge was Mr 4's statement which has not been admitted into evidence. Additionally, the panel was not provided with the MAR chart recording the medication administered to patient BF. The panel noted that in your disciplinary hearing on 8 February 2019 you disputed this charge. It took account of the notes of your disciplinary hearing which stated:

> *"Valsamma's account was that she had administered medication correctly, and had been searching for tablets in the bedding as she had seen the patient spit the tablet out, without further details from Konrad his concern could not be progressed."*

The panel noted that the concern giving rise to Charge 1b could not be progressed at the time of your disciplinary hearing due to a lack of information. On the basis of the admissible evidence the panel determined that there was insufficient evidence before it to be capable of proving Charge 1b.

Charge 1c:

c) *On 21 October 2017, having been informed that patient BF had abdominal pain and/or suffering from the retention of fluids by a nursing assistant did not take action to reduce the fluids in patient BF's bladder.*

In relation to Charge 1c the panel bore in mind that in the notes from your disciplinary hearing on 8 February 2019 you appear to have accepted some elements of this charge. On the evidence before it, the panel considered that there was a case to answer in respect of Charge 1c.

Charge 1d:

d) *On 21 October 2017, performed a bladder scan on patient BF using an incorrect technique, namely, by incorrectly moving the scanner up and down on patient BF's abdomen.*

In relation to Charge 1d, the panel was of the view that, taking account of the admissible evidence before it, it could not find the facts of charge 1d proved. The panel noted that the only evidence which could have supported this charge was Mr 4's statement which has not been admitted. In the absence of other evidence to support this charge the panel decided that you do not have a case to answer in respect of Charge 1d.

Charge 1e & Charge 1f:

e) *On 21 October 2017, having received a bladder scan reading of 437 millilitres did not take account of the previous bladder scan reading of 417 millilitres and catheterise patient BF.*

f) *On 21 October 2017, did not document the results of the bladder scan reading in patient BF records, namely the reading taken of around 437 millilitres.*

In relation to both Charges 1e and 1f, the panel was of the view that, taking account of the admissible evidence before it, it could not find the facts of these charges proved. The panel noted that the only evidence of there having been a bladder scan reading on 437 millilitres came from Mr 4's statement which has not been admitted. In the absence of other evidence to support these charges the panel decided that you do not have a case to answer.

Charge 1g:

g) *On 14 December 2017 did not explain the cannula process to patient CF prior to inserting a cannula*

In relation to Charge 1g, the panel was of the view that, taking account of all the evidence before it, it could not find the facts of charge 1g proved. The panel noted that Ms 1stated in her oral evidence that there was no suggestion that it was you who had inserted the cannula in relation to patient CF, as such, that it would not have fallen to you to explain to process of insertion. In view of Ms 1's oral evidence the panel determined that you had no case to answer in respect of charge 1g.

Charge 1h:

h) On 2 July 2018 inserted a cannula into patient W's arm without obtaining consent to perform the procedure from the patient.

In relation to Charge 1h, the panel was of the view that, taking account of the admissible evidence before it, it could not find the facts of Charge 1h proved. The panel bore in mind that the only evidence which could have supported this charge was the statement of Ms 6, which had not been admitted. In the absence of any evidence to support Charge 1h, the panel decided that you had no case to answer.

The panel noted that Charge 1i is admitted.

Charge 1j:

j) On the 3 July 2018 did not carry out safe and effective medicines management, in that you signed for medication which you had not administered in the morning to (female) patient X.

In relation to Charge 1j the panel took into account the interview notes dated 13 August 2018 in which you are recorded as having stated:

> *"It was bed 24 an independent patient. The drug chart for the patient was there; I prepared the medication in the room and signed the drug chart. When I went back the patient wasn't there in the bed, they had gone off the ward. I kept the medication in their cupboard and locked it. When I came back they didn't have it that's true...*
>
> *...No, I prepared the medication the she wasn't there so I locked the cupboard...*
>
> *...Legally you are supposed to sign when you give the drug that that's not practical. If you sign later you can make a human error and may forget to sign and if someone else is looking at it if I didn't sign there is a chance they could re-administer it. It is safe to sign so that they are not getting double, legally ok its* not, but practically but it's the safest side. I have prepared the medicine..."

On the basis of the notes of your interview dated 13 August 2018 the panel determined that there was a case to answer in respect of this charge.

Charges 2 & 3:

2) *On 20 December 2017 signed a medication record to indicate that you had administered Enoxaparin (Clexane) when you had not administered the said medication at the time of signing the medication record. MS*

3) *On or around 20 December 2017 administered a dose of Enoxaparin when you were uncertain as to whether you had already administered a dose of Enoxaparin in the preceding 24 hours to the same patient. MS*

In relation to Charges 2 and 3 the panel noted that it is recorded in your investigation interview that you stated that you thought you missed the Clexane injection because you had to give the patient a nebuliser first and that you said that you did not remember giving the Clexane injection but remembered disposing of the syringe. The Datix report indicates that the dose was subsequently given at 8pm, after the patients' family asked why the medication had not been given. On this basis of your interview notes and the Datix report, the panel determined that there was a case to answer in relation to Charges 2 and 3.

The panel noted that Charge 4 is admitted

Charge 5:

5) On 1July 2018 failed to treat patient T appropriately in that you:

a) Removed a continence pad without any communication or explanation of your actions;

b) Did not obtain consent from the patient to remove a continence pad;

c) Removed the said continence pad without providing the patient adequate privacy by leaving the curtains near to the patient open and/or the patient exposed.

In relation to charge Charges 5a, b, and c, the panel was of the view that, taking account of the admissible evidence before it, it could not find the facts of charge 5 proved. The

panel bore in mind that the only evidence which could have supported these charges was the statement of Ms 6, which had not been admitted into evidence. In addition, you denied this charge in your local interview on 13 August 2018. In the absence of any admissible evidence to support Charges 5a, b, and c, the panel determined that you had no case to answer.

Charge 6:

6) *On 3 July 2018 failed to follow the correct manual handling practice, namely by pulling patient W by their shoulder without the assistance of another member of staff.*

In relation to Charge 6 (which the panel declined to amend for reasons stated earlier), the panel was of the view that, taking account of the admissible evidence before it, it could not find the facts of charge 6 proved. The panel noted that the only evidence which could have supported Charge 6 was the statement by Ms 6, which has not been admitted into evidence. Further, in the interview on 13 August 2018 you denied this charge. On the evidence before it, the panel determined that you had no case to answer in respect of Charge 6.

Decision and reasons on facts

At the outset of the hearing you admitted charges 1i and 4. The panel therefore finds charges 1i and 4 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 Mr Evans on behalf of the NMC, and your oral evidence.

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.

Background

The NMC received a referral from University Hospitals Bristol NHS Trust on 10 March 2019 where you were working as a registered nurse. This referral raised a number of concerns regarding your practice as set out in the original charges. During the course of the hearing you admitted charges 1i and 4. The panel has previously found that there was no case to answer in respect of a number of the charges, with the consequence that only charges 1c, 1j, 2 and 3 remained to be determined at this stage.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

Decision and reasons on amending charge 1c

Of its own volition, the panel proposed amending charge 1c in accordance with Rule 28. The proposed amendment was to add the word ‘appropriate’ as set out below:

Charge 1c

1) Were not able to demonstrate the standards of knowledge skill and judgement required to practice in that you:

    c) On 21 October 2017, having been informed that patient BF had abdominal pain and/or suffering from the retention of fluids by a nursing assistant did not take **appropriate** action to reduce the fluids in patient BF's bladder.

The panel accepted that advice of the legal assessor in respect of the proposed amendment.

Neither Mr Evans nor you made any submissions on the matter.

The panel determined to amend the Charge 1c, as proposed, because it considered that it would more accurately reflect the issue behind the charge. The issue to which this charge was directed is not that you had failed to act at all, but that you had not acted in a timely and appropriate manner in catheterising Patient BF. The panel considered this issue to be more accurately set out by the insertion of the word 'appropriate' within Charge 1c.

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

Charge 1c

1) Were not able to demonstrate the standards of knowledge skill and judgement required to practice in that you:

    c) On 21 October 2017, having been informed that patient BF had abdominal pain and/or suffering from the retention of fluids by a nursing assistant did not take appropriate action to reduce the fluids in patient BF's bladder.

This charge is found proved.

In reaching this decision, the panel took into account the care log and fluid balance chart for Patient BF, both dated 21 October 2017. The fluid balance chart indicates that at 9pm a bladder scan demonstrated that Patient BF's bladder contained 417ml of urine. It is also reported in the fluid balance chart that between 9pm and 11pm Patient BF received a further 300ml of oral fluid. The care log indicates that at 10pm on 21 October 2017 Patient BF was becoming increasingly agitated. However, you did not catheterise Patient BF until 7am on 22 October 2017.

Ms 2 gave oral evidence that a fluid reading of 500ml can be used as a guide for when to consider catheterisation. You, in your evidence, agreed that you were aware of this guidance and you stated that at some point you spoke with a doctor who advised you not to catheterise Patient BF unless necessary.

The panel also took account of the notes of your disciplinary hearing on 8 February 2019 in which you are recorded as having said:

> *"The nursing assistant said that the patient didn't pass urine and was distressed and also had bladder problem, dementia and suffers from restlessness. The catheter should have been given if necessary but the doctor didn't write that a catheter was needed."*

You stated in oral evidence that you could not remember looking at the fluid balance chart or the care log. The panel considered the fluid balance chart to have been significant information in assessing Patient BF's care needs. It is recorded in the care log that at 7am on 22 October 2017 she was in pain. To the panel, you did not appear to have reconsidered the clinical need to catheterise Patient BF and the possibility that bladder discomfort was causing Patient BF to be agitated.

When catheterised at 7am on 22 October 2017 840ml of fluid was drained from Patient BF's bladder, a significant amount in excess of the 500ml recognised as a guide for considering catheterisation.

The panel found that you waited too long to catheterise Patient BF and that waiting until the patient was and increasingly agitated and in pain was inappropriate and was indicative of a lack of knowledge, skill and judgement.

The panel therefore found Charge 1c proved.

Charge 1j

j) On the 3 July 2018 did not carry out safe and effective medicines management, in that you signed for medication which you had not administered in the morning to (female) patient X.

This charge is found proved.

In reaching this decision, the panel took into account the interview notes dated 13 August 2018 in which you are recorded as having said:

> *"The drug chart for the patient was there; I prepared the medication in the room and signed the drug chart. When I went back the patient wasn't there in the bed, they had gone off the ward. I kept the medication in their cupboard and locked it. When I came back they didn't have it, that's true."*

The panel also had regard to the Trust's policy at the time on recording the administration of medicines which stated as follows:

- *The accountable practitioner who has administered or supervised the administration of the drug must, at the time of administration, sign with initials in the*

appropriate column on the medicines chart or in the appropriate place on the EPMA record.

- *Do not leave a patient without ensuring he/she has taken the medicine.*
- *Never sign or complete the administration field for a drug until it has been administered.*

During your disciplinary hearing, and during you oral evidence you conceded that you signed for medication that you did not administer. In the interview notes dated 13 August 2018 you are recorded as having said:

> *"Legally you are supposed to sign when you give the drug that that's not practical. If you sign later you can make a human error and may forget to sign and if someone else is looking at it if I didn't sign there is a chance they could re-administer it. It is safe to sign so they are not getting double, legally ok its not, but practically but it's the safest side. I have prepared the medicine."*

You repeated this explanation during your oral evidence. On the basis of the evidence before it, and your admission that you did not administer the medication at the time you signed for it, the panel found Charge 1j proved in that you failed to demonstrate the necessary knowledge, skill and judgement to administer medications safely.

Charge 2

2) On 20 December 2017 signed a medication record to indicate that you had administered Enoxaparin (Clexane) when you had not administered the said medication at the time of signing the medication record. MS

This charge is found proved.

The panel took account of the notes of your disciplinary hearing on 8 February 2019 in which you are recorded as having said:

> *"I remember that I signed for it but this patient suffers from breathlessness and I probably forgot this...*
>
> *...Look at the Drug Chart and then explain to the patient then give the medicine. Legally were not supposed to sign but sometimes I give and I will forget to sign. So instead of giving a double dosage, I sign...*
>
> *...As I am aware it is different from patient to patient and they have all sorts of conditions so I will usually sign..."*

In view of these statements, and on the balance of probabilities, the panel finds Charge 2 proved.

Charge 3

3) On or around 20 December 2017 administered a dose of Enoxaparin when you were uncertain as to whether you had already administered a dose of Enoxaparin in the preceding 24 hours to the same patient. MS

This charge is found proved.

In reaching this decision, the panel took into account the Datix report of the incident dated 20 December 2017. The following is included in the report:

“The nurse from day shift went on to give 90mg clexane even though she said she had 5 minutes previously she had definitely given the clexane at 18:00. Nurse who put the datix in was concerned that the nurse from day shift didn’t seem to know if she had given it or not but still went on to give dose, ?double dose or ? whether signed for earlier in day but not administered [sic].”

The Datix report indicates that you administered a dose of Clexane despite your belief that you had already administered an earlier dose. On the basis of this Datix report, which you accepted in your oral evidence as accurate, the panel finds Charge 3 proved.

[This hearing resumed on 1 September 2021]

When the hearing resumed on 1 September 2021 all parties remained the same with the exception of the panel secretary. The panel handed down its decision and reasons on the facts before moving on to consider fitness to practise.

Fitness to practise

The panel acknowledged that having found no case to answer in respect of the misconduct charges (charges 5 and 6), it would only have to consider whether the remaining charges found proved amount to lack of competence 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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence and impairment

The NMC has defined a lack of competence (Reference: FTP-2b Last Updated: 14/04/202) as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

Mr Evans referred the panel to the NMC'S guidance on Lack of competence (Reference: FTP-2b Last Updated: 14/04/2021), in particular:

'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.'

Mr Evans also referred the panel to the case of *Calhaem, R (on the application of) v General Medical Council [2007] EWHC 2606 (Admin)*. He submitted that the facts found proved fell below the standards expected of a registered nurse and amounted to lack of competence. Mr Evans submitted that the areas of concern related to fundamental aspects of nursing practice, including record keeping and medication administration. He submitted that the charges represent a fair sample of your work in that the errors which gave rise to the charges occurred on six occasions between October 2017 and July 2018. Mr Evans submitted that the errors occurred despite you receiving a good level of support from the Trust who allowed you the opportunity to improve your practice by moving you to a different ward on a supernumerary basis.

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

Mr Evans identified the specific, relevant standards where he submitted your actions amounted to a lack of competence. He submitted that the facts found proved demonstrate that your competence at the time was below the standard expected of a registered nurse.

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

Mr Evans submitted that at the conclusion of the hearing in May 2021 (as you had admitted two charges), you were provided with the NMC guidance on insight and remediation to assist you in preparing for this resuming hearing. Despite having being given this guidance, Mr Evans submitted that you have not provided a reflective statement or any evidence of remediation. He submitted that this demonstrates lack of insight and that as a result of this, and no evidence of remediation, there is a risk of repetition of the errors and a consequent risk of harm to patients. He therefore invited the panel to find that your fitness to practise is currently impaired on public protection and public interest grounds.

To assist you in your submissions you agreed to the panel asking you a number of questions. You informed the panel that you have done some reading in an attempt to keep your nursing knowledge up to date. You said that you have not completed any relevant training courses since 2016. You have not worked in a clinical setting in any capacity since your dismissal from the Trust.

When asked about whether you have reflected on the charges found proved you submitted that you accept some of the charges and that you made mistakes which wouldn’t happen again. You submitted that in the future you would be more careful.

In response to a question from the panel about your training needs you submitted that you do not think that you needed any additional training and that you are confident in your clinical abilities. You submitted that mistakes do not always arise from a lack of training and that they can occur because of a particular situation. When asked by the panel to elaborate on what situation prevented you from delivering best practice you were unable to provide any specific examples.

When prompted by the panel you accepted that the charges found proved are serious and had the potential to cause patient harm. In respect of medication administration and record keeping, you stated that you know that legally you are supposed to give medication to a patient before you record it, however, you submitted that it is safer to make an entry before you administer the medication. You said that if you give the medication and then forget to record that it has been administered, another dose of the medication could be given and result in patient harm due to an overdose.

You submitted that you felt supported by the Trust and on the ward where you worked on a supernumerary basis. When the panel asked whether you had anything further to say you asked *"when will I be going back to work?"*.

The panel accepted the advice of the legal assessor.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, it found that you had fallen short of the following standards:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice.

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event...

10.3 complete records accurately...

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

To achieve this, you must:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures…

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 bore in mind that when reaching its decision, you should be judged by the standards of the average registered nurse and not by any higher, or more demanding standard.

The panel considered that the errors you made that gave rise to the charges found proved involved an unacceptably low standard of professional performance. The panel noted that the shortfalls occurred in fundamental areas of nursing practice, namely; medication administration, catheter care, communication with colleagues and documentation.

The panel considered that the charges found proved represent a fair sample of your work. These occurred on six separate occasions, over a significant period of time between October 2017 and July 2018. Despite the Trust moving you to a different ward on a supernumerary basis a further error occurred in July 2018.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was below the standard that one would expect of the average registered nurse acting in your role.

In all the circumstances, the panel determined that your performance identified in the charges found proved demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide whether as a result of the lack of competence your fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their performance 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 *Grant* in reaching its decision. In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" in relation to fitness to practise 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 found that patients were put at risk due to your lack of competence which included unsafe medication administration. Furthermore, the panel determined that lack of competence in catheter care, namely your delay in catheterising Patient BF, caused her pain and discomfort. Your lack of competence breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

In considering whether you were liable in the future to place patients at unwarranted risk of harm, bring the medical profession into disrepute or breach fundamental tenets of the medical profession, the panel had regard to your level of insight and remediation.

As you are unrepresented, at the close of the last hearing (in the knowledge that the hearing would proceed to the next stage in view of your admissions to some of the charges), the panel invited the legal assessor and Mr Evans in the presence of the panel secretary to provide you with some guidance on the next stage. You were also give the NMC's written guidance to assist you in preparing for this stage of the hearing. The panel noted that you had not produced any documentary evidence of reflection, insight or remediation.

In your oral submissions in respect of medication administration, you maintained your position that while you accept that the correct approach is to administer medication first and sign after, you think that it is safe to sign first and then administer medication after. You were unable to demonstrate any understanding of why it is important to follow the correct procedure. In your submissions you tried to justify your errors as being mistakes that would not happen again. You said that mistakes often happen due to specific situations, but you were unable to explain this statement. The panel considered that you while you made some admissions to the charges, you were unable to properly reflect on the shortfalls in your practice or demonstrate any meaningful insight into your lack of competence. You did not express any remorse.

The panel first considered whether the lack of competence is remediable. The panel determined that given that the errors are clinical in nature, and relate to a lack of competence, they are eminently remediable. In respect of remediation, the panel noted that you have not worked as a registered nurse or in any other capacity in a clinical setting since you were dismissed by the Trust. In your submissions you stated that you have done some online reading but you did not give any details about this and you have not completed any training courses. Whilst remediable, the panel found that you have not yet remediated your practice.

In view of your lack of insight into your shortcomings the panel determined that there is a real risk of repetition and a consequent risk of harm to patients. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, given your lack of competence and the risk of repetition and consequent risk of harm to the public, a finding of impairment on public interest grounds was required.

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

Submissions on sanction

Mr Evans informed the panel that the NMC were seeking the imposition of a conditions of practice order for a period of 12 months.

Mr Evans outlined some features that he submitted were aggravating and mitigating in this case. He submitted that a conditions of practice order was the appropriate and proportionate order in this case. Mr Evans suggested some conditions that would, in his submission, protect the public and give you the opportunity to demonstrate that you are capable of safe and effective practice.

You made no submissions at this stage, however, in response to a question from the panel you said that you would be willing to comply with a conditions of practice order.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your fitness to practise currently impaired by reason of your lack of competence, 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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel noted that, as this is a 'lack of competence' case, a striking off order is not an available sanction until at least two years from the imposition of the substantive sanction has elapsed.

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. 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 has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC.

The panel took into account the following aggravating features:

- Your lack of insight into the impact of your lack of competence on patients, colleagues, the profession and public interest.
- Your lack of competence placed patients at risk of harm and caused Patient BF discomfort and pain.
- You have made no efforts to remediate your practice.
- You expressed no remorse for the impact of your lack of competence on patients.

The panel took into account the following mitigating features:

- You made some admissions to the charges.
- Although the Trust proposed a mentoring programme to assist you in achieving competency it did not in fact take place.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness and the fundamental nature of your lack of competence. Having determined that there is a risk of repetition of the lack of competence identified, and a consequent risk of harm to patients, the panel was of the view that an order that does not restrict your practice would be inappropriate as it would not protect patients. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order. It determined that such an order would be inappropriate and it would not address the public protection and public interest concerns in this case for the same reasons as set out above for taking no further action.

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 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.

Having determined that your lack of competence is eminently remediable, the panel was of the view that it would be possible to formulate appropriate and practicable conditions which would address the shortfalls identified in this case. The panel noted that your lack of competence related to medication administration, documentation, catheter care and effective communication with colleagues. It determined that patients would be protected by the imposition of conditions that specifically address the shortfalls identified in your practice. The panel was of the view that you would benefit from a conditions of practice order as this provides a structured and supportive programme to give you the opportunity to achieve competency, and to demonstrate that you are capable of safe and effective practice. The panel accepted that you would be willing to comply with a conditions of practice order.

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 be a reasonable response in the circumstances of your case at this stage because it would not allow you the opportunity to remediate your practice.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order would protect the public as well as marking the importance of maintaining public confidence in the profession, and sending 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 ensure that you are supervised by a senior registered nurse of band 6 or equivalent 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 senior registered nurse of band 6 or equivalent or above.

2. You must not administer medication unless directly supervised by a senior registered nurse of band 6 or equivalent until you have been assessed as competent in the administration and recording of medications. You must send your case officer evidence when you have been assessed as competent in the administration and recording of medications.

3. You must work with your line manager, mentor or supervisor to create a personal development plan (PDP). Your PDP must address the following concerns:
    - Fluid balance management.
    - Understanding indications for urinary catheterisation.
    - Safe and effective medicines management including administration and recording.
    - Effective communication with colleagues.

    You must:

    a) Meet with your line manager, mentor or supervisor at least monthly to discuss your progress towards achieving the aims set out in your PDP.
    b) Send your case officer a copy of your PDP prior to any review of this order.
    c) Send your case officer a report from your line manager, mentor or supervisor prior to any review of this order.

4. You must keep your case officer at the NMC 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.

5. You must keep your case officer at the NMC 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.

6. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

7. You must tell your case officer at the NMC, 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.

8. You must allow your case officer at the NMC 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.

The period of this order is for 12 months. The panel was of the view that 12 months would allow you sufficient time to gain employment as a registered nurse and to remediate the shortfalls identified in your practice.

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.

This panel considered that any future panel reviewing this order may be assisted by the following:

- Your attendance at any review hearings.
- A written reflective statement (using a recognised model) from you to demonstrate your understanding of the impact of your lack of competence (fluid balance management, understanding indications for urinary catheterisation, safe and effective medicines management including administration and recording and effective communication with colleagues) on patients and their families, the nursing profession and the wider public.
- Evidence of what you have done to keep your nursing knowledge and skills up to date.

Decision and reasons on interim order

The panel has considered the submissions made by Mr Evans that an interim order should be made to cover the appeal period. He submitted that an interim order is necessary to protect the public, and that it is in the public interest, and to do otherwise would be inconsistent with its determination. He invited the panel to impose an interim conditions of practice order for a period of 18 months to cover the appeal period and any appeal if made.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim conditions of practice order is necessary to protect patients and is otherwise in the public interest. The panel had regard to the seriousness and nature of the lack of competence found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be inconsistent with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the condition of practice order 28 days after you are sent the decision of this hearing in writing.

This will be confirmed to you in writing.

That concludes this determination.