Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Hearing
21 – 24 February and 28 February – 3 March 2022
25 April – 3 May 2022

Virtual Hearing

Name of registrant:	Maureen Keenan
NMC PIN:	89E0328S
Part(s) of the register:	Registered Nurse Learning Disabilities Nurse – September 1992 Mental Health Nursing – August 2002
Area of registered address:	West Dunbartonshire
Type of case:	Misconduct
Panel members:	Peter Swain (Chair, Lay member) Diane Gow (Registrant member) David Hull (Lay member)
Legal Assessor:	Nigel Mitchell
Hearing Co-ordinator:	Ruth Bass Roshani Wanigasinghe (3 May 2022)
Nursing and Midwifery Council:	Represented by Alban Brahimi, counsel instructed by the NMC
Mrs Keenan:	Present and represented David Blair, counsel instructed by the RCN
Facts proved:	3 in respect of Clients D E H I J K, 4a, 5a, 5d, 6, 7, 8b ii, 8b iii, 8b iv in respect of a choking incident, 9a i and 9a ii
Facts not proved:	1a, 1b, 2, 3 in respect of Client G, 4b, 5b, 5c, 5e, 8a and 8b i
Fitness to practise:	Impaired

Sanction:	Suspension order (6 months) with a review
Interim order:	Interim Suspension order (18 months)

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

The legal assessor gave advice relating to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules), following mention of your health during the hearing. 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.

Mr Brahimi and Mr Blair agreed that any reference to your health should be heard in private.

The panel, having heard that matters of your health had been mentioned, determined that any reference to your health should be considered private.

Consideration of an interim order upon decision to adjourn

When the hearing adjourned on 3 March 2022 the panel gave consideration as to whether it should impose an interim order. The panel was informed by Mr Brahimi that an interim conditions of practice order was currently in place and was due to expire on 16 March 2022. He informed the panel that the NMC had put steps in place to request that the order be extended.

Mr Blair set out what the current conditions of practice are, and submitted that he did not oppose the current order remaining in place as it was necessary and proportionate.

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

Having been advised that an interim conditions of practice order was in place, the panel considered that the only thing to have changed was that you had admitted some of the charges at the outset of the hearing. The panel was of the view that the public and the

public interest would be protected by the continuation of the current interim condition of practice order.

Details of charge

1) Between 2017 and January 2019, failed to maintain accurate records in that you, on one or more occasions:
   a) did not complete and/or update patient record[s] within a timely manner or at all as set out in Schedule A;
   b) did not ensure that one or more of your patient records were up to date and/or completed on the Trust's electronic clinical record system;

2) Between October 2018 and January 2019, did not complete an assessment for one or more of your patients and/or their children within a timely manner or at all;

3) Between October 2018 and January 2019, on one or more occasions did not attend and/or complete a visit of your patient[s] as set out in Schedule B;

4) In respect of Client A, following a significant event on or around 14 January 2019:
   a) Did not complete a significant event record for Client A's child;
   b) Did not document that Client A had been removed from the child protection register;

5) In January 2019, did not provide sufficient information in Client B's patient record and/or assessment in that you:
   a) Did not record Client B's child's SIRS number;
   b) Did not record the health visitor caseload number;
   c) Did not complete Client B's perinatal mental health pathway;
   d) Did not complete a lone worker risk assessment form;
   e) Did not task a nurse to visit;

6) Between approximately November 2018 and February 2019, did not complete one or more data forms in relation to Client B in a timely manner or at all;

7) On approximately 22 October 2018, did not offer the Family Nurse Partnership programme to Client C in a timely manner or at all;

8) In respect of Client E, following a significant event on or around 18 December 2018:

    a) Did not complete a significant event record for Client E's child;
    b) Did not take any and/or sufficient action in that you:
        i) Failed to make contact with Client E;
        ii) Did not undertake a safety/hazard check of Client E's home;
        iii) Did not undertake a well-being check of Client E and her child;
        iv) Did not demonstrate to Client E how to perform CPR and/or handling a choking incident;

9) Displayed unprofessional behaviour in that you:
    a) On 5 February 2019, towards Colleague A:
        i) spoke in a loud manner and/or shouted;
        ii) spoke in an angry and/or hostile and/or abrupt manner:

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

Schedule A

Client A

Client B

Client C

Client D

Client E

Schedule B

Client D

Client E

Client G

Client H

Client I

Client J

Client K

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Blair, who informed the panel that you made full admissions to charges 4a, 5a, 5d, 8a and 8b iv. Admissions to charges 8a and 8b iv were later withdrawn in the light of your oral evidence.

The panel therefore finds charges 4a, 5a and 5d 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 Brahimi on behalf of the Nursing and Midwifery Council (NMC) and by Mr Blair on your behalf.

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

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

- Colleague A: Family Nurse Supervisor (Band 7) at Cairnbrook Centre (part of the Family Nurse Partnership).
- Colleague B: Family Nurse (Band 7) at Cairnbrook Centre (part of the Family Nurse Partnership).
- Colleague C: Family Nurse Supervisor at Cairnbrook Centre (part of the Family Nurse Partnership) and from August 2017 Temporary Family Nurse Consultant for the Board.

The panel also heard evidence from you under affirmation.

Background

The charges arose whilst you were employed as a Band 7 Family Nurse at Cairnbrook Centre (the Centre) which is part of the Family Nurse Partnership (the Partnership). You started working at the Centre in 2012, which at that time used a paper based system for client records. In 2015 the NHS Greater Glasgow and Clyde Health Board (the Board) transitioned from a paper based system to an electronic recording system known as EMIS.

You went on sick leave between July 2017 and August 2017 and at some point upon your return to work at the Centre, Colleague A became your line Manager.

Clinical supervision meetings were undertaken by Colleague A with you on 14, 21 and

27 September 2017 and 17 October 2017.

It is alleged that you told Colleague A on 14 September 2017 that you had completed assessments with clients, recorded on paper, that were not put onto the client recording system and that Colleague A had set out why it was important for any outstanding assessments to be completed and put onto EMIS as soon as possible.

On 21 September 2017, it is alleged that you agreed with Colleague A that you would have all of your caseload assessments and notes of visits up to date within two weeks, and a deadline was set during a further meeting on 27 September 2017. During a meeting on 17 October 2017, it became clear that you were still not up to date with your client assessments and notes.

Between 1 November 2017 and 15 January 2018 you went on a period of sick leave.

On 18 January 2018 a clinical supervision meeting was held by Colleague A with you. It was discussed what support would be available to you upon your return to work. It is alleged that at this meeting Colleague A stressed the importance of you catching up on your work as there were still notes from visits and assessments that had not been uploaded to the EMIS system.

Clinical supervision meetings were held by Colleague A with you on 30 January 2018 and 8 February 2018.

Between 14 February 2018 and September 2018 you were on a further period of sick leave.

On 22 October 2018 a meeting was held between you and Colleague A to discuss what support was available to you. Further supervision meetings were held with you by Colleague A on 30 October 2018, 8 November 2018, 14 November 2018 and 28

November 2018. During this time, you were allocated a reduced caseload as part of the support for you following your period of sick leave.

Colleague A was of the opinion that, as of 8 November 2018, there were still notes and assessments carried out by you that had not been uploaded to the EMIS system. It is alleged that you were asked to ensure the system was updated.

During a meeting with you on 28 November 2018, it is alleged that Colleague A told you that all outstanding data must be uploaded to the EMIS system by 31 December 2018, as the Partnership was migrating to a different information technology (IT) system. You informed Colleague A during this meeting that you were having IT difficulties and could not access your clients on the system.

It is alleged that Colleague A offered you support which included working with the Data Manager, exploring alternative means of access to IT, working in different sites to gain better access, and showing you where to find the EMIS Guidance on record keeping which detailed how to keep records.

You went on annual leave from 24 December 2018 returning on 7 January 2019. On 28 January 2019 you attended a residential training course for 1 week.

Further clinical supervisory meetings were held with you by Colleague A on 8 January 2019 and 22 January 2019.

Colleague A met with you again on 22 January 2019. It is alleged that at this meeting you agreed that all client records would be updated by mid-February 2019.

On 5 February 2019 it is alleged that you displayed poor professional behaviour towards Colleague A by shouting and acting in an angry and hostile manner towards her.

It is alleged that you kept client records which were either incomplete or not up to date between 2017 and January 2019. It is further alleged that you failed to conduct client visits between October 2018 and January 2019 as per the Service Level Agreement of the Partnership. It is further alleged that you displayed poor professional conduct towards Colleague A by speaking to her in a loud and angry manner.

In respect of a specific client, it is alleged that you did not take any or any sufficient action in response to the client's child suffering a choking incident.

On 11 March 2019 you submitted your resignation to the Partnership.

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

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

Charge 1 a

1) Between 2017 and January 2019, failed to maintain accurate records in that you, on one or more occasions:

a) did not complete and/or update patient record[s] within a timely manner or at all as set out in Schedule A;

Client A: This charge is found NOT proved in respect of Client A.

In considering this charge in respect of Client A the panel took into account that it was not provided with evidence of the date by which Client A's patient records needed to be updated by, and was not informed when Client A was transferred to you. Colleague A

was only able to say that Client A was transferred to you at some point between October and December 2018. The panel noted that Client A could have been transferred to you in December 2018. It further took into account that you had a period of leave over the Christmas holiday, and that in late January 2019 you attended residential training for a week.

The panel considered the Get It Right For Each Child (GIRFEC) record for Client A and noted that it had been completed by you by the end of January 2019. Furthermore in the absence of specific information as to when Client A was transferred to you, and given your leave and training commitments, the panel could not find that you had not completed or updated Client A's records in a timely manner. It therefore found this charge not proved in respect of Client A.

Client B: This charge is found NOT proved in respect of Client B

The panel noted that charges 5 and 6 raised specific issues about your record keeping in respect of Client B. The panel was unable to identify evidence that would support an allegation about Client B's record keeping that was not covered under charges 5 and 6. Having found there to be no additional failures to charges 5 and 6, it was of the view that charge 1 a), in respect of Client B, is a duplication of charges 5 and 6. It accordingly found this charge not proved in respect of Client B.

Client C: This charge is found NOT proved in respect of Client C.

In respect of Client C, the panel was unable to identify any evidence in respect of failing to maintain accurate or timely records. It had regard to the Progress Notes for Client C and noted, to the contrary, that there was evidence of detailed records of attempts by you to contact Client C. There was no evidence before the panel to support the charge of failing to maintain records and no specifics as to what information it is alleged you have not recorded. The panel therefore found this charge not proved in respect of Client C.

Client D: This charge is found NOT proved in respect of Client D.

In considering this charge, the panel had regard to the Progress Notes of Client D. This client was transferred to you on 26 November 2018. The panel noted that there were 6 dated entries by you, from 3 December 2018 to 20 December 2018, after which you went on leave. It was clear to the panel that records had been kept by you in timely manner and as such it found this charge, in respect of Client D, not proved.

Client E: This charge is found NOT proved in respect of Client E.

With regard to Client E, the panel considered the Progress Notes for Client E and noted entries made by you on 2, 14, 25 and 26 November 2018. It noted in particular the entry of 14 November 2018 which states:

'Mother [Client E] and [unknown] present. Mother very open during visit.'

The panel acknowledged that your recording in clients' records during December 2018 had reduced. However, it was satisfied that there had been accurate records made by you from 2 November 2018 through to 26 Nov 2018. As with other clients under this charge, the panel could not identify what information it is alleged you did not record. It therefore found charge 1 a) not proved in respect of Client E.

Charge 1 b

1) Between 2017 and January 2019, failed to maintain accurate records in that you, on one or more occasions:

b) did not ensure that one or more of your patient records were up to date and/or completed on the Trust's electronic clinical record system;

This charge is found NOT proved.

In considering this charge the panel had regard to the oral evidence of Colleague A. Colleague A stated during cross-examination:

> *'...some of the more simple ones were updated, and some of the more complex ones, the standard wasn't what would be expected in terms of the audit. I can't in all honesty…tell you how many she had done and how many were updated, but I know that there were still some outstanding. There was some progress but it was limited and there were still some gaps, particularly in the input of the clinical data which would then finish the whole assessment for the client and the child.'*

The panel noted that it had not been provided with the EMIS records for the clients in question. It noted that there were a lot of general references with regard to EMIS not being updated, but there was no specificity as to which client(s) the records related to.

Whilst it did appear there was a general issue about progress towards completing the entries into the EMIS electronic system, the panel was not presented with the records or specifics with regard to individual clients that would enable it to assess whether the records were up to date or completed. It should have been possible for the NMC to obtain this evidence but it had not done so. The panel concluded that the charge was not sufficiently particularised or evidenced such as to be fair to you. It was of the view that the NMC had not met the burden of proof and therefore found this charge not proved.

Charge 2

> 2) Between October 2018 and January 2019, did not complete an assessment for one or more of your patients and/or their children within a timely manner or at all;

This charge is found NOT proved.

In considering this charge, the panel had regard to the letter dated 22 October 2018 addressed to you from the Partnership, sent following your meeting with Colleague A upon your return to work following a considerable period of leave. The panel had regard to the fact that there was an acknowledgment in this letter that you yourself volunteered that some pregnancy key issues assessments were still outstanding. However in addressing the charge, the panel noted that there was no specific assessment identified as not having been completed. On the contrary, the panel had sight of the supervision meeting notes in November 2018 which evidenced that you had completed some client assessments throughout the month of November 2018.

The panel found the evidence adduced in respect of this charge to be general in nature and lacking in specificity. No information had been provided identifying which client assessments remained outstanding or how many. In light of the lack of specificity in this charge, the panel did not find it proved.

Charge 3

> 3) Between October 2018 and January 2019, on one or more occasions did not attend and/or complete a visit of your patient[s] as set out in Schedule B;

Client D: This charge is found proved.

The panel heard evidence from Colleague A that Client D had been allocated to you on 26 November 2018.

The panel had regard to Client D's Progress Notes and noted that there had been 5 attempts by you to contact Client D in December 2018. In particular the panel noted that it was recorded in the Progress Notes on 17 December 2018 that Client D would be away for 1 week. You attempted to call her again on 20 December 2018 but she was

unavailable. The panel also took into account that you were due to go on leave on 24 December 2018, and in late January 2019 attended a week long training course.

The panel determined that, as a matter of fact, you did not did not attend or visit Client D. However, it notes that you attempted to make arrangements to visit Client D, which proved difficult throughout November and December 2018 including because she was away in Ayr for part of the time. However, there is no evidence of you making any attempt to contact Client D in January 2019. In fact, Client D took the initiative to contact the service herself on 24 January 2019 having heard nothing further. Client D was 15 years old and therefore highly vulnerable. On the basis of your failure to follow up in January 2019 on making arrangements to visit the client, the panel found this charge proved.

Client E: This charge is found proved.

The panel noted that charge 8 included issues relating to visiting Client E after a choking incident on 18 December 2018. The panel therefore confined its consideration of this charge to the period prior to 18 December 2018. It noted there was no record of a visit between 14 November and 18 December 2018. It therefore found this charge proved in respect of Client E.

Client G: This charge is found NOT proved.

In considering this charge in respect of Client G, the panel had regard to Client G's records. It noted that there was an initial visit on 25 October 2018, which was the engagement visit and 5 subsequent visits post Client G being enrolled despite your leave in December 2018 and the subsequent training you undertook in late January 2019. The panel was of the view that the factors of your leave and subsequent training were important in considering how many visits should have taken place. It therefore found this charge not proved in respect of Client G.

Client H: This charge is found proved.

The panel heard evidence from Colleague A that you should have undertaken 7 visits. It noted from Client H's records that you had an initial enrolment visit on 6 November 2018, and 3 subsequent visits on 20 November 2018, 5 December 2018 and 17 December 2018, with the scheduled visit on 4 December 2018 being cancelled. The panel noted that there were no visits in January 2019. It again took into account that you went on leave from 24 December 2018 and had a week of training in late January 2019, and that Client H was a working mother with work commitments.

Nonetheless, the panel noted that no visits were carried out in January 2019 by you, and accordingly found this charge proved in respect of Client H.

Client I: This charge is found proved.

The panel had regard to Client I's records and noted that the initial enrolment visit took place on 26 October 2018 and was followed by visits on 1 November 2018, 21 November 2018 and 7 December 2018, with one visit cancelled by Client I on 4 December 2018.

The panel was satisfied that under the terms of the programme there should have been a period of regular visits to the client. However, it was of the view that even taking into account your leave over the Christmas period and the week long training you undertook in late January 2019, there was nevertheless a need for visits in January 2019. The panel had regard to the fact that no visits to Client I were conducted by you in January 2019. It therefore found this charge in respect of Client I proved.

Client J: this charge is found proved.

The panel had regard to Client J's records. It noted that the initial enrolment visit took place on 20 December 2018 and that there were no follow up visits to Client J.

The panel had no evidence of any follow up in January 2019. It therefore found this charge proved in respect of Client J.

Client K: this charge is found proved.

The panel had regard to Client K's records. It noted that the initial enrolment visit took place on 17 December 2018 and that there was one follow up visit on 19 December 2018. There was no evidence of any follow up visits after 19 December 2019. Therefore the panel found this charge proved in respect of Client K.

Charge 4 a

4) In respect of Client A, following a significant event on or around 14 January 2019:

a) Did not complete a significant event record for Client A's child;

This charge is found proved by your admission.

The panel noted you admitted this charge at the outset of the hearing. It further noted that you updated Child A's record on 18 January 2019, rather than immediately following the significant event.

Charge 4 b

4) In respect of Client A, following a significant event on or around 14 January 2019:

b) Did not document that Client A had been removed from the child protection register;

This charge is found NOT proved.

The panel noted this charge should have referred to Client A's child.

In reaching this decision, the panel had regard to your notes contained in Client A's child's assessment form dated 28 January 2019 which stated:

> *'…a Child Protection Case Conference was held on the 14-1-19 and the decision was made to remove name from the child protection register.'*

It was clear to the panel from this document that you did document the fact that Client A's child had been removed from the child protection register. It therefore found charge 4 b not proved.

Charge 5 a

5) In January 2019, did not provide sufficient information in Client B's patient record and/or assessment in that you:

    a) Did not record Client B's child's SIRS number;

The panel noted your admission to this charge. It had regard to the fact that you accepted that you did not record Client B's child's SIRS number on 22 January 2019, but did so on 26 January 2019.

Charge 5 b

5) In January 2019, did not provide sufficient information in Client B's patient record and/or assessment in that you:

    b) Did not record the health visitor caseload number;

This charge is found NOT proved.

In considering this charge the panel had regard to Client B's First Visit Report dated 22 January 2019. It noted that the health visitor caseload number, although not recorded under the box entitled *'Health Visitor caselad (sic) number'*, was recorded on the form under *'Health visitor – professional number'*. It therefore found this charge not proved.

Charge 5 c

5) In January 2019, did not provide sufficient information in Client B's patient record and/or assessment in that you:

c) Did not complete Client B's perinatal mental health pathway;

This charge is found NOT proved.

The panel noted that it had been provided with 2 different versions of Client B's Perinatal Mental Health Pathway: one was incomplete and the second version (exhibit 6) provided to you by the NMC at the time of the case examiners' report but not included in the NMC's bundle of evidence submitted to this panel. The panel noted with concern that it was left to you to put forward this directly relevant evidence, the NMC having omitted it. The panel noted that there were no provenance issues with regard to exhibit 6. The panel therefore found this charge not proved.

Charge 5 d

5) In January 2019, did not provide sufficient information in Client B's patient record and/or assessment in that you:

d) Did not complete a lone worker risk assessment form;

This charge is found proved by your admission.

Charge 5 e

5) In January 2019, did not provide sufficient information in Client B's patient record and/or assessment in that you:

e) Did not task a nurse to visit;

This charge is found NOT proved.

In considering this charge the panel had regard to your oral evidence. You told the panel that you had a discussion with a Family Nurse colleague in respect of a visit to Client B and gave her a handover. Colleague A confirmed, in her oral evidence, that the Family Nurse colleague did visit Client B. There was no evidence before the panel to suggest that the Family Nurse Colleague did not know the position with Client B. The panel was therefore of the view that the visit to Client B resulted from your verbal handover to the Family Nurse colleague and therefore you did *"task"* this visit.
The panel therefore found this charge not proved.

Charge 6

6) Between approximately November 2018 and February 2019, did not complete one or more data forms in relation to Client B in a timely manner or at all;

This charge is found proved.

In considering this charge the panel had regard to the statement of Colleague A which states:

'I had spoken to the Registrant about these data forms during discussions on 8 November 2018…14 November 2018…and 28 November 2018…I asked the Registrant to complete the remaining data forms by December 2018. The Registrant agreed to this and said that the forms would be completed by December 2018.'

The panel noted that you had been put on notice to complete data forms in respect of Client B since 8 November 2018, and had agreed to do so by the end of December 2018.

The panel also had regard to the clinical supervision meeting notes dated 22 January 2019, signed by both you and Colleague A, which set out that the outstanding client records should be updated by you by *'mid February'*. The panel noted that the initial deadline set for December 2018 had not been met by you by 22 January 2019, and that no satisfactory explanation had been provided by you as to why they were not complete. Further the panel noted that another deadline was then agreed upon until the middle of February 2019. It was therefore clear to the panel that you had not completed one or more data forms between November 2018 and February 2019, despite having the need to complete these forms explained to you during the clinical supervision meetings in November 2018. It therefore found charge 6 proved.

Charge 7

7) On approximately 22 October 2018, did not offer the Family Nurse Partnership programme to Client C in a timely manner or at all;

This charge is found proved.

The panel had regard to Client C's progress notes and noted that this client had been accepted by you on 22 October 2018. Client C was highly vulnerable, having suffered a previous still birth. The first evidence of any attempt to contact Client C was on 1

November 2018, when you attempted to contact Client C on her mobile number, but there was no response. The panel also noted that no further attempt to contact Client C was made by you until 3 December 2018. The panel was of the view that this was sufficient to establish that you did not make sufficient attempts to offer the Partnership in a timely manner or at all to Client C on approximately 22 October 2018. It therefore found charge 7 proved.

Charge 8 a

8) In respect of Client E, following a significant event on or around 18 December 2018:

a) Did not complete a significant event record for Client E's child;

This charge is found NOT proved.

The panel had regard to Child E's record of consultations and noted the following record made on 18 December 2018 by you:

'Significant event reported: appointment cancelled
Significant event description: text received from mother, XXX chocked [sic] on his dinner and attended A&E
Impact on child: Positive medical support received
Action: Further visit offered for 21-12-18'

The panel determined that you did complete a significant event record for Child E and therefore found this charge not proved.

Charge 8 b i

8) In respect of Client E, following a significant event on or around 18 December 2018:

b) Did not take any and/or sufficient action in that you:

i) Failed to make contact with Client E;

This charge is found NOT proved.

The panel had regard to your oral evidence and Client E's record of consultations. It noted that you accepted that you did not call Client E, but denied the charge on the basis that you did contact Client E by way of a text message on 18 December 2018 in which you stated that you offered a further visit for 21 December 2018. It was subsequently recorded that Client E cancelled that visit. The panel was satisfied that Client E had received an offer of a visit from you which meant you must have contacted her. The panel therefore found this charge not proved.

Charge 8 b ii

8) In respect of Client E, following a significant event on or around 18 December 2018:

b) Did not take any and/or sufficient action in that you:

ii) Did not undertake a safety/hazard check of Client E's home;

This charge is found proved.

The panel noted you accepted that you did not visit and therefore did not conduct a safety/hazard check, but that you deny that this represented not taking any and/or

sufficient action. The panel noted that Client E's child was by this stage six months old. In the light of the choking incident, which had resulted in attendance at an Accident and Emergency department, it was not sufficient to rely on previous safety assessments when considering Client E's child's current welfare. It was important to exclude the possibility of new risks being present, for example from the child's likely increased mobility, and from the introduction of weaning. The panel noted that on 30 January 2019 Colleague A conducted the sort of comprehensive review of safety/hazard risks that you should have carried out in response to the choking incident. The panel concluded that you did not take any or sufficient action to assess the current safety/hazard risks in Client E's home in the light of the choking incident. The panel accordingly found this charge proved.

Charge 8 b iii

8) In respect of Client E, following a significant event on or around 18 December 2018:

b) Did not take any and/or sufficient action in that you:

iii) Did not undertake a well-being check of Client E and her child;

This charge is found proved.

In considering this charge, the panel had regard to your oral evidence and noted that you accepted that you did not undertake a well-being check. You did not think that it was necessary to undertake a well-being check, despite the incident being a traumatic event for both mother and baby. The panel noted that Colleague A visited Client E on 30 January 2019 and that, in a very comprehensive assessment, recorded that Client E had found the experience *"terrifying".* The panel therefore found this charge proved.

Charge 8 b iv

8) In respect of Client E, following a significant event on or around 18 December 2018:

b) Did not take any and/or sufficient action in that you:

iv) Did not demonstrate to Client E how to perform CPR and/or handling a choking incident;

This charge is found proved in respect of handling a choking incident.

In considering this charge the panel had regard to your oral evidence. You told the panel that you were not qualified to teach CPR and *'wouldn't be qualified how to teach a parent how to give CPR to a child.'*

The panel also considered the evidence of Colleague A. It had regard to the fact that Colleague A was also a Band 7 Nurse, and when she visited Client E following the choking incident did not demonstrate to Client E how to perform CPR either. The panel was of the view that there is a distinction between knowing how to undertake CPR and teaching someone to carry out CPR.

However, the panel had regard to the fact that Colleague A did show Client E how to deal with a choking incident by demonstrating with a doll. The panel also heard evidence from Colleague A that you should have been able to support, advise and ensure Client E received the right advice or techniques by yourself. The panel was of the view that you could have also done this through sign posting to a relevant professional or programme. It was satisfied that there was a need to demonstrate how to handle a choking incident to avoid a repetition based on the evidence of Colleague A. The panel was of the view that it was incumbent upon you to do it or sign post to someone who could impart this knowledge, and you did not do this. The panel therefore found this charge proved in respect of handling a choking incident, but not in respect of CPR.

Charge 9 a i

9 Displayed unprofessional behaviour in that you:

a) On 5 February 2019, towards Colleague A:

i) spoke in a loud manner and/or shouted;

This charge is found proved.

The panel had regard to your oral evidence. You told the panel that although you were upset due to Colleague A's manner towards you, you did not raise your voice and remained calm during the exchange.

The panel also had regard to the evidence of Colleague A and Colleague B.

The panel had regard to the following evidence from Colleague A's statement and oral evidence respectfully:

> *'Although the Registrant was not shouting, she did not say this quietly and she said it with a very sharp and abrupt tone' and I invited her to come into the office but she declined,*
>
> *'No, I'm not coming in. I'm just here to tell you that I'm leaving FNP'. And at that point she turned away, and then shouted over her shoulder, 'And you can tell [Colleague C] that she'll be hearing from me in due course'.*

The panel considered Colleague A's evidence to be balanced. She was clear that you were not speaking quietly and that you shouted at one point over your shoulder.

The panel also had regard to the evidence of Colleague B who was in an office of the corridor where the exchange took place. Colleague B gave evidence that you were shouting. Colleague B gave evidence on her proximity to the discourse. She told the panel that another colleague, from elsewhere in the building, had come to her crying and distressed as a result of the impact of the incident.

The panel found Colleague B's description persuasive. Having heard that Colleague B was able to hear the exchange between you and Colleague A, the panel determined on the balance of probabilities that it was more likely than not that you had spoken in a loud manner and shouted. It also found that to have done so amounted to unprofessional behaviour. It therefore found this charge proved.

Charge 9 a ii

9 Displayed unprofessional behaviour in that you:

a) On 5 February 2019, towards Colleague A:

ii) spoke in an angry and/or hostile and/or abrupt manner:

This charge is found proved.

In considering this charge, the panel had regard to its finding in charge 9 a) i) above. It also had regard to Colleague A's evidence that your *'language was hostile. [You] had both fists clenched and [your] jaw was clenched and [you] had a very firm expression on [your] face. [You looked quite angry].* The panel preferred Colleague A's evidence to your evidence and found that it is more likely than not that you did speak in an angry, hostile and abrupt manner. The panel also found that to have done so amounted to unprofessional behaviour. It therefore found this charge proved.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

Mr Brahimi invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision and identified specific standards where he submitted your actions amounted to misconduct.

Mr Brahimi took the panel through the charges found proved and pointed out where he submitted that your conduct had fallen short. He also pointed out the vulnerability of the clients and the risk of harm posed to them by your failures. Overall Mr Brahimi submitted that your actions fell far short of what would be expected of a registered nurse. He submitted that the public, patients and colleagues would not expect that

individuals responsible for young people's care at various stages of pregnancy were cared for in such a way, and that there is an expectation that nurses should uphold the reputation of the profession.

Mr Brahimi 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 Brahimi submitted that your fitness to practise is impaired. He submitted that clients were put at an unwarranted risk of harm and that there was a real risk of harm to patients. He further submitted that there is a real risk of repetition given that the charges took place over a period of time and were wide ranging. In addition the misconduct was not corrected despite guidance and supervision being put in place.

Mr Brahimi submitted that a finding of impairment is also required in the public interest. He submitted that a member of the public would be concerned to learn that a registrant is allowed to practice unrestricted given the risks identified, and that the attitude displayed by you would affect the reputation of the profession.

Mr Brahimi further submitted that a fellow practitioner would find your actions deplorable. With regard to charge 9, he submitted that colleagues are entitled to feel safe in the work place.

Mr Blair informed the panel that you had now had an opportunity to reflect on its findings, and you now accept that your actions amount to misconduct and that your fitness to practise is currently impaired. Mr Blair informed the panel that although you acted on the basis of your honestly held beliefs at the time, you now had an opportunity

to see why the panel found the charges proved. He told the panel that you accepted its findings, and with hindsight now know that you ought to have acted differently.

With regard to charge 9, Mr Blair informed the panel that your memory of the incident is not shared with your former colleagues, but you accepted that you were extremely emotional and that the panel may find a basis for misconduct. He also invited the panel to consider that this charge was an entirely different species of conduct from the other facts found proved.

Mr Blair informed the panel that you have not been working as a nurse since the events, but have sought to keep up to date with nursing theory.

Mr Blair reminded the panel that you do wish to return to nursing in the sphere of child and adolescent psychiatric care and that you previously had a distinguished career in psychiatric nursing.

Mr Blair submitted that you are committed to the vocation of being a nurse and have acted in good faith.

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

Decision and reasons on misconduct

Notwithstanding your admission that your actions amount to misconduct and that your fitness to practise is currently impaired, both matters fall to be determined by the panel.

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

the word professional which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which would qualify. The professional conduct must be serious…''

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
>
> ***4 Act in the best interests of people at all times***
> *To achieve this, you must:*
>
> *4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*
>
> ***8. Work co-operatively***
>
> *To achieve this, you must:*
>
> *8.6 share information to identify and reduce risk*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:*
>
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

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

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

20 Uphold the reputation of your profession at all times.

The panel acknowledged that breaches of the Code do not automatically result in a finding of misconduct. The panel was of the view that the charges found proved could be categorised under three distinct areas of practice, namely:

- Failure in record keeping and visiting clients, and adherence to the requirements of the programme;

- In respect of Client A and Client E, failures to record a significant event and respond to risks and safety issues which arose; and

- Professional behaviour

With regard to failures in record keeping and visiting clients the panel considered the culmination of failings together with the significant period of time over which the failings occurred. Further the panel took into account the considerable support which had been put in place on a number of occasions, to include being given a significantly reduced caseload, being offered the opportunity to work alongside the Data Manager, and being offered alternative locations to enhance IT access in addition to a number of supportive training programmes. Your line manager also offered to swap her place on a training programme so that you could attend.

The panel also had regard to the fact that your failures in this regard related to a particularly vulnerable client group of young pregnant women and mothers, who were put at risk. It had regard to the fact that the Family Nurse Partnership programme is predicated on face to face support and engagement, and by not keeping accurate records, or responding when clients presented in times of need was unacceptable. It was of the view that your failings did fall far below the standard expected of a registered nurse and amounted to misconduct.

With regard to Client A and Client E, the panel took into account that you failed to complete a significant event record for Client A's child when required, and failed to provide a level of support or assessment of health and safety in Respect of Client E and her child. The panel was of the view that the risks to the clients in both of these cases were significant, in that critical information in respect of Client A's child would not have been available to other health professionals involved in her care and, with regard to Client E there could have been an ongoing risk to Client E's child, as well as to Client E's welfare.

The panel was of the view that there were clear risks to both Client A and Client E which would be expected to be recognised by all registered nurses, let alone a nurse at your level of seniority. The panel was also concerned by your failure to follow up Client C in a

timely manner. Again, Client C was highly vulnerable and you should have made all reasonable efforts to recruit her into the programme at the earliest opportunity. The panel was of the view that your failures in identifying these risks were deplorable and amount to misconduct.

With regard to the finding in respect of professional behaviour found proved in charge 9 the panel was of the view that your behaviour may have been partly influenced by a series of stressful work related events. The panel determined that your actions amounted to unacceptable unprofessional behaviour that should not have occurred. However, it did not find that your actions met the threshold required for serious misconduct.

The panel therefore found that your actions, with the exception of charge 9, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. 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 conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not*

only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;…'*

The panel determined that clients and their children were placed at an unwarranted risk of harm as a result of your misconduct. The client group you were working with were particularly vulnerable and required a level of care and oversight which you failed to provide by failing to identifying risks and taking appropriate action. It therefore found that by failing to provide the service required, you had brought reputation of the profession into disrepute.

The panel also determined that you had breached fundamental tenets of the nursing profession, namely by failing to uphold the reputation of the profession, sharing information to reduce risk to clients and identifying risks that arise and taking action to deal with them.

Regarding insight, the panel was of the view that you failed to recognise fundamental errors and failures with regard to your practice, and displayed an inability to respond appropriately to risks that would be expected of a nurse. The panel acknowledged that you now fully accepted its findings on the facts. However, it was of the view that your insight in this respect has only now come following the conclusion, and as such the panel could only say that your insight is at the most formative stage requiring meaningful and substantial development.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel noted that you have not been practicing as nurse since these events and have not been working in a clinical environment. It noted that you have not provided any evidence of continuing professional development, but have read some general nursing literature. The panel was of the view that in light of there being limited evidence that you have strengthened your practice, combined with your newly emerging insight which is yet to be tested in practice, there is a real risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required. It was of the view that your actions and omissions affected a particularly vulnerable client group and that members of the public would be concerned to learn that a nurse who had not strengthened her practice were allowed to practise unrestricted. Further, the panel was of the view that there was a need to declare and uphold clear professional standards by marking that the level of practice demonstrated by your misconduct is not proper or acceptable. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has decided to make a suspension order for a period of six months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

Mr Brahimi, whilst recognising that the decision and sanction was for the panel alone, submitted that the NMC considered a suspension order for a period of three months, to be the appropriate sanction.

Mr Brahimi invited the panel to consider what the NMC found to be the aggravating and mitigating features of this case. He submitted that your practice involved working with children, the concerns raised were around highly vulnerable clients, the findings are serious and recognise the potential risk of harm with an associated risk of repetition. Mr Brahimi submitted that the supervision and other support afforded to you could be viewed as tantamount to conditions of practice, which were insufficient to address your misconduct.

Mr Brahimi therefore submitted that that the appropriate sanction in this case is a suspension order for a period of three months. This would reflect the seriousness of your conduct and serve to maintain public confidence that the NMC do take such findings seriously and will take appropriate action.

Mr Brahimi reminded the panel that whilst a striking off order is an option available to the panel, it is not an approach that the NMC would currently adopt as being proportionate in all the circumstances.

Mr Blair invited the panel to impose a conditions of practice order as the appropriate sanction in your case. He noted the principles applied within such cases. He reminded the panel that the purpose of sanctions is not to punish but to protect the public. He further reminded the panel of the need for any sanction to be proportionate.

Mr Blair submitted that you have had a long and distinguished nursing career, particularly in child and adolescent mental health. He submitted that there are no previous concerns in your practice and that you are otherwise of good character. He drew the panel’s attention to a reference provided on your behalf, which attests to you having a good and lengthy career. It attested to you providing good care to your patients and clients. Mr Blair further submitted that you have understood and acknowledged the importance of good record keeping being a basic tenet of the profession.

Mr Blair accepted that insight may be at an early stage as found by the panel at the previous stage. However, he submitted that you have shown some insight and wished to continue practising as a nurse. Mr Blair informed the panel that you have sought to keep up-to-date with psychiatric nursing. He highlighted to the panel the context of the concerns identified, in that you had some difficulties with your managers, and had health concerns at the time. He submitted that these must be considered in context and are part of the factors which contributed to the misconduct identified.

Mr Blair told the panel that you have not been working as a nurse since the instigation of these NMC proceedings, however, you are due to start a new role this week as a support worker with a home care service who provides care to the elderly. He submitted that this role would give you an opportunity to undertake a quasi-nursing role. However, he informed the panel that the employer had indicated that the offer would likely be withdrawn if your registration was to be temporarily or permanently removed.

Mr Blair submitted that the matters leading to the finding of misconduct relate to clinical practice which are remediable. He submitted that they are not intrinsic to your character and related to your competence and clinical ability. He therefore submitted that these concerns can be addressed through a conditions of practice order. He reminded the panel of your willingness to comply with any conditions imposed. He invited the panel to consider conditions such as requiring a Personal Development Plan (PDP), evidence of attendance at training events such as in record keeping and training assessments and a condition relating to supervision meetings with a line manager. He submitted that it would not be necessary to impose either direct or indirect supervision as such conditions may hinder your ability to obtain work and return to nursing.

Mr Blair submitted that a suspension order would be inappropriate given the circumstances of your case.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- By the nature of your misconduct, vulnerable mothers and babies were put at risk;
- Significant lack of insight into your actions and the potential risk to which you exposed children and their mothers;
- Multiple incidents which took place over a 5-month period, relating to a number of clients; and
- You held a position of seniority namely, a band 7 nurse.

The panel also took into account the following mitigating features:

- The panel heard that you had a previous long career at senior level in child and adolescence psychiatry, prior to your role with the FNP.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, the public protection and public interest issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The Sanctions Guidance states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and*

the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel noted that there are practical or workable conditions that could be formulated, given the nature of the findings in this case. However, the panel noted that you had been provided with considerable support from the Centre. This included regular supervision with clear and specific action plans, a reduced caseload, and offers of training. Despite requests by your line manager on a number of occasions to complete a learning needs analysis, this was never completed.

Notwithstanding this considerable support, concerns continued to arise, including some involving basic nursing standards around record keeping and safeguarding. The panel was particularly concerned that you have shown very little insight into the seriousness of these concerns, and have offered no evidence to this panel of substantive efforts to demonstrate that you have strengthened your practice to address the risk of repetition. What insight you have shown is limited to accepting the findings of the panel. You have maintained the view that you acted in good faith in that you were not duty bound to act differently.

In these circumstances, the panel determined that imposing a conditions of practice order would be insufficient to protect the public and the public interest, given the specific circumstances of your case and especially taking account of your current level of insight.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel considered your lack of meaningful insight or recognition of the impact of your failings on clients, their children, your colleagues and the wider profession. It bore in mind the client group you were working with were particularly vulnerable and required a level of care and oversight which you failed to provide. It further bore in mind that despite considerable support by the Centre, matters did not improve.

The panel determined that a suspension order for a period of six months would allow you the time you need to reflect on the findings of this panel as to your misconduct and take the steps necessary to meaningfully demonstrate that your practice has been strengthened. The panel was of the view that this period of suspension would enable you to provide substantive evidence of your future practice intentions and progress in addressing the concerns raised above. The panel also determined that a period of six months was required to maintain public confidence in the profession given the concerns raised in this case.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order at this stage.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order would inevitably cause you. However this is outweighed by the public interest in this case.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement with the NMC;
- Your attendance at the review hearing;
- A Personal Development Plan (PDP) detailing how you intend to address the concerns identified;
- A structured written reflective piece using a recognised model which demonstrates your understanding of;
    - the concerns identified above;
    - the effect of your misconduct on patients/clients, their families, the nursing profession and the public's perception of nurses; and
    - how you would approach similar circumstances differently in the future.
- Evidence that you have kept your clinical skills and nursing knowledge up to date; and
- Any testimonials commenting on your recent performance in the workplace practice from either paid or voluntary positions.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

Mr Brahimi submitted that interim suspension order for a period of 18 months would cover the 28 days before the substantive suspension order comes into effect, and the subsequent appeal period should you appeal the decision. He submitted that the grounds for this would mirror the panel's earlier decision, that it is necessary for the protection of the public and is otherwise in the public interest.

Mr Blair submitted that he did not oppose this application.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months given the seriousness of the facts found proved and in the interest of protecting the public and in maintaining public confidence in the nursing profession and the NMC as a regulator.

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

That concludes this determination.