Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 6 February 2023 – Friday 10 February 2023
Monday 13 February 2023 – Friday 17 February 2023
Monday 18 September 2023 – Friday 22 September 2023
Monday 25 September 2023 – Tuesday 26 September 2023
Monday 11 December 2023 – Friday 15 December 2023

Nursing and Midwifery Council
10 George Street, Edinburgh, EH2 2PF

Name of Registrant:	**Israel Kubatsirwa Jamera**
NMC PIN	06I0023O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 5 September 2006
Relevant Location:	Scottish Borders
Type of case:	Misconduct
Panel members:	Phillip Sayce (Chair, Registrant member) Margaret Marshall (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	John Moir
Hearings Coordinator:	Charis Benefo
Nursing and Midwifery Council:	Represented by Toby Pleming, Case Presenter (6 – 17 February 2023) Represented by Katharine Muir, Case Presenter (18 – 26 September 2023 and 11 – 15 December 2023)
Mr Jamera:	Present and represented by Tom Docherty, Anderson Strathern (6 – 17 February 2023) Present and represented by Chris Weir, Anderson Strathern (18 – 26 September 2023 and 11 – 15 December 2023)

Case Management Meetings:

5 July 2023

Hearings Coordinator:	Christine Iraguha
Nursing and Midwifery Council:	Represented by Yusuf Segovia, Case Presenter
Mr Jamera:	Represented by Chris Weir, Anderson Strathern

4 August 2023

Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Hazel McGuinness, Case Presenter
Mr Jamera:	Represented by Chris Weir, Anderson Strathern
Facts proved by admission:	Charges 2a, 2b and 6
Abuse of process:	Charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1b)iii and 1b)iv
Facts proved:	Charges 1b)v, 5a, 5c and 7a
Facts not proved:	Charges 3, 4, 5b and 7b
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on further disclosure

At the outset of the hearing, the Chair indicated that there were significant omissions in the documentary exhibit bundle for this case, relating to patient identifiers and/or dates which had been redacted. As a result of these redactions, it was not clear which patient records related to the patients outlined in charges 1 to 3. The Chair was concerned as no anonymity key had been provided to ascribe the patient records to the patients specified in the charges.

The Chair invited Mr Pleming, on behalf of the Nursing and Midwifery Council (NMC), to source unredacted versions of these patient records, so as to produce an anonymity key. The Chair determined that in line with procedure, this information was necessary to ensure accuracy.

Mr Pleming informed the panel that the unredacted patient records were not available "*in a way that the panel would like to see*". He stated that the NMC would have to request this documentation from Borders General Hospital (the Hospital), but it was his submission that it would be disproportionate to do so. Mr Pleming submitted that he would not reasonably expect the NMC to receive this documentation from the Hospital immediately, and it was likely to take some time. He told the panel that all of the evidence had been placed before the panel and submitted that these redacted patient records only related to one of seven charges.

Mr Pleming reminded the panel that matters in this case are "*quite old*" and submitted that it would not be in either of the parties' interests for this case to be delayed. He referred the panel to Witness 3 and Witness 4's witness statements and submitted that there was clear evidence that patient charts were incomplete. Mr Pleming referred to the redacted patient records and said that the records exactly mirrored the evidence given in these witness statements. Mr Pleming submitted that there would be no unfairness to you if this case were to proceed without sourcing the unredacted copies of these patient records.

Mr Docherty, on your behalf, submitted that panels have an obligation to ensure that cases run properly, and thus need to take a more proactive approach. He said that the panel had been provided with charges which particularised patients 1 to 6, but the documentary evidence had not been particularised. He submitted that it did not seem a difficult exercise to request unredacted patient records from the Hospital. Mr Docherty submitted that ultimately, it was a matter of fairness to you. If the charges were to be found proved, then they would be particularly serious and could affect the future of your nursing career. He submitted that particular care was required when dealing with allegations of this kind and so allowing the NMC to proceed with the case with the redacted patient records would not be proper.

The panel heard and accepted the advice of the legal assessor which included reference to the case of *PSA v NMC & Jozi* [2015] EWHC 764 (Admin).

The panel considered that these particular issues related to charges 1, 3 and 4. It took into account the seriousness of these charges and determined that it was important to identify the patient records which related to the patients outlined in the charges.

The panel directed the NMC to approach the Hospital and ascertain whether they could provide the original unredacted patient records, so that these documents could be cross-referenced and consequently ascribed to the patients contained in the charges. The panel noted its previous experience of a rapid turnaround of documents, particularly with NHS Scotland who have been efficient with assisting with past cases. The panel considered that it could be possible for these unredacted patient documents to be made available by day two of these proceedings. It noted that the NMC witnesses who are still working at the Trust would be able to assist with this matter; otherwise it should be sought from the Hospital. The panel determined that there were routes available to the NMC to source these documents without undue delay.

Details of charge

That you, a registered nurse:

At Borders General Hospital:

1. On a night shift 24/25 February 2018 failed to complete a NEWS (National Early Warning Score) set of observations for the patients in Room 1 as follows:
    a. Patient 1 at:
        i. 10pm.
        ii. 2am.

    b. At 2am for:
        i. Patient 2.
        ii. Patient 3.
        iii. Patient 4.
        iv. Patient 5.
        v. Patient 6.

2. On a night shift 24/25 February 2018 failed to escalate the care of Patient 6 to:
    a. The Shift Coordinator, and/or
    b. The HAN (Hospital at Night) Team.

3. Made a record of a 2am NEWS score of 7 retrospectively on the NEWS chart for Patient 6 for 25 February 2018.

4. Your action at 3 was dishonest in that you intended to mislead any reader of the NEWS chart that you had carried out a complete NEWS set of observations around 2am on 25 February 2018 when you knew you had not done so.

At Drummohr Care Home:

5. On 7 February 2020 after recording a pulse rate of 36 for patient 7:
    a. Failed to escalate the patients care, and/or
    b. Failed to seek a second opinion, and/or
    c. Failed to take a full set of observations within 2 hours.

6. Around 7 February 2020 administered PRN (When Required) Diazepam to Patient 8 on four consecutive days without recording a reason on the back of the MAR (Medicines Administration Record).

7. On 12 February 2020:
    a. Failed to respond promptly to an emergency alarm.
    b. After Patient 9 fell to the floor failed to conduct a full body check.

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

At the outset of the hearing, the panel heard from Mr Docherty, who informed the panel that you made admissions to charges 2a, 2b and 6.

The panel therefore found charges 2a, 2b and 6 proved, by way of your admissions.

Background

You first entered onto the NMC's register on 5 September 2006.

The NMC received a referral in respect of you on 31 January 2019 from NHS Borders. You were employed as a Staff Nurse at the Hospital within the Medical Assessment Unit (MAU) since 2007. The allegations in this case are that on the night shift spanning 24/25 February 2018, you failed to conduct a National Early Warning Score (NEWS) set of

observations for patients. You also allegedly failed to escalate the care of Patient 6 to the Shift Coordinator and/or the Hospital at Night (HAN) team. It is alleged that you retrospectively recorded a 02:00 NEWS entry on Patient 6's observation chart, when you had told colleagues at some point after 02:00 that the observations had not been done.

The second set of allegations in this case arose whilst you were employed as a Staff Nurse at Drummohr Care Home (the Home). You started working at the Home on 25 November 2019. It is alleged that on 7 February 2020, you failed to escalate patient care in respect of Patient 7. You are alleged to have also administered Diazepam to Patient 8 on four consecutive days without recording a reason on their MAR. On 12 February 2020, you allegedly failed to respond promptly after a patient had suffered a fall, and failed to conduct a full body check afterwards.

Decision and reasons on application to recall the NMC's witnesses

On day six of the proceedings and after the panel had heard from the NMC's live witnesses, Mr Docherty informed the panel of a matter that had not been put to Witness 3 and Witness 4 during their live evidence. It had been your position that when you returned from your break on the night shift spanning 24/25 February 2018 at the Hospital, you were told in the corridor by Witness 4 that the observations had already been conducted "*apart from the side rooms*". Mr Docherty stated that he wished to put your position, which had been omitted in error to the witnesses. Mr Docherty submitted that in fairness to you and the panel, this matter would need to be addressed.

Mr Docherty referred the panel to Rule 22(4) of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) which provided that '*any further questioning of the witnesses shall be at the discretion of the Committee*.' Mr Docherty reminded the panel that the charge which alleges dishonesty is serious. He asked the panel to consider a plan of action to establish your position, and made the suggestion that the witnesses be presented with a written question, to which they could provide a written response. Alternatively, the panel was invited to consider the matters in the round within

the context of all of the evidence before it at the appropriate stage. He further submitted that should the panel not be with him on the preceding approaches, then Witnesses 3 and 4 could be recalled.

Mr Pleming did not object to you advancing evidence that had not been put to the NMC's witnesses in totality. It would be ultimately for the panel to draw such inferences as it deemed appropriate as regards the weight of any evidence from you that had not been put to the NMC's witnesses. Mr Pleming submitted that this matter was not an issue for the NMC, and that the NMC should not have to recall the witnesses. He referenced how busy nurses can be and how intrusive these proceedings can be in regard to timing. Mr Pleming submitted that in respect of the witnesses, they had been released and their evidence had been concluded.

In response to Mr Pleming's submissions, Mr Docherty stated that his only observation was that Witness 4 was retired and not presently working as a nurse.

The panel accepted the advice of the legal assessor.

The panel noted that your position had not been put directly to Witness 3 and Witness 4 in respect of your conversation with Witness 4 on the night shift spanning 24/25 February 2018. It took into account that this had been as a result of an omission which was not your fault. The panel considered fairness to you in this regard and was satisfied that it would not be disproportionate to hear additional evidence from the NMC's witnesses on your position at this stage. The panel determined that, as the missing evidence concerned a matter in issue, it was important to consider hearing from the witnesses.

The panel considered the evidence it had already heard from Witness 3 about communications with you and Witness 4 at around 02:00 and 04:00 during the night shift. The panel determined that it would not recall Witness 3 because she had provided a clear account of what she could and could not recall about these conversations in her oral

evidence. The panel therefore determined that it would not require Witness 3 to be recalled on the matter raised by Mr Docherty.

The panel then considered the evidence it had heard from Witness 4 about her conversation with you in respect of patient observations during the night shift. The panel noted that there had been some ambiguity in her evidence regarding the content of the conversations at the material times and determined that on this basis, it would be appropriate that your position be put to Witness 4 in order to ascertain her response. As a matter of fairness to you, the panel determined that it was appropriate to investigate the possibility of Witness 4 being recalled solely to address this discrete issue.

The panel therefore directs the NMC to make a prompt approach to Witness 4 to determine her availability to give further evidence within the allocated hearing dates.

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

Mr Docherty made a request that this case be held partly in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19.

Mr Pleming did not oppose the application.

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.

The panel determined to hold in private the parts of this hearing that involve reference to [PRIVATE] as and when such issues are raised, in order to protect your privacy. It was satisfied that this course was justified and that the need to protect your privacy outweighed any prejudice to the general principle of public hearings.

Case management issues

On day seven of the proceedings and during your live evidence under oath, Mr Pleming raised an issue with regard to the documentary evidence relating to Patient 6. He asked the panel for an opportunity to take instructions from the NMC on the matter and the panel granted his request.

In the intervening period, the panel identified further concerns relating to the adequacy of the documentation before it.

The panel was particularly concerned about the completeness of the documentation which had been provided by the NMC in respect of the Patient 6 and Patient 9 for charges 2 and 7, respectively.

In relation to Patient 6, the panel noted your admission to charge 2, namely that you failed to escalate Patient 6's care to the Shift Coordinator and the HAN (Hospital at Night) Team. The panel had heard oral evidence from Witness 4 regarding Patient 6's care on the MAU from 23 February 2018 until their death on 25 February 2018. It also had sight of Patient 6's observation charts which indicated that their NEWS Score had been recorded as '*7*' prior to the night shift spanning 24/25 February 2018, but that no action had been taken to escalate their care throughout the day. The panel considered that it had not been provided with any contextual information about Patient 6's care in the period preceding their death on 25 February 2018. It determined that such information would be necessary to assist in its decision on whether your omissions in respect of Patient 6 would amount to serious professional misconduct, during the impairment stage of these proceedings.

Regarding Patient 9, the panel took into account the discrepancies of your oral evidence and the evidence of Witness 2 relating to the incident with Patient 9. However, no documentary evidence had been provided to the panel in respect of this incident. Witness

2 had, however, made reference to contemporaneous documentation relating to the incident with Patient 9, including a DATIX form said to be completed by you.

The panel had regard to Mr Pleming's submissions that it had already heard all of the relevant evidence from the NMC's live witnesses and that it would be disproportionate to require further information from the Home in respect of Patient 9. However, the panel took into account the case of *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin) which provided guidance on how panels should deal with evidence. The panel was satisfied that a DATIX report recording Patient 9's fall on 12 February 2020 might provide relevant information about the details of Patient 9's fall and which staff member, if any, undertook a full body check after the incident. The panel determined that these records were necessary to assist in its decision on the facts in respect of charge 7.

The panel therefore directed the NMC to provide the following documentation:

- All of Patient 6's records dated from 23 February 2018 up to and including 25 February 2018, and in particular, any notes, ward records or ward diaries about Patient 6 and any documentation regarding whether he should be put on end of life care from the Hospital; and
- The DATIX report relating to Patient 9's fall on 12 February 2020, as well as her patient records for the 24-hour period following the incident from the Home.

On day eight of the proceedings, Mr Pleming provided the panel with an update on the NMC's progress with the panel's directions. He told the panel that the NMC Case Co-ordinator had been making enquiries with the Hospital and the Home, and that she would pass on any information as and when it arrived. Mr Pleming invited the panel to decide on the proposed way of moving forward with the case.

Decision and reasons on the matter of releasing you from your oath

On day eight of the proceedings, the Chair identified that in the absence of any information as to when the requested documentation from the Home would be provided to the panel, it would be pertinent to take submissions on whether you should be released from your oath.

Mr Pleming stated that the starting position was that those in the middle of giving live evidence under oath or affirmation do not speak to their legal representatives in order for their evidence to be given "*with their own mind*". It was not his suggestion that Mr Docherty or you would do anything untoward, but he submitted that releasing you from your oath at that stage would not be in line with "*the rules*". Mr Pleming submitted that it would not be disproportionate to keep you on oath until further information could be provided about the documentation from the Home. He submitted that this would avoid any suggestion of impropriety. Mr Pleming submitted that if the panel were minded to release you from your oath, then he would invite the panel to make a strong direction that you do not discuss your evidence with anyone, including Mr Docherty.

Mr Docherty highlighted his duty to the panel, which outweighed his duty to you as a client. He submitted that on one hand, it was disproportionate for you to remain on oath for an unspecified period of time, but that on the other hand, he accepted Mr Pleming's reasonable assertion. He submitted that there was no suggestion of any impropriety if you were to be released from your oath, and reiterated that as a solicitor, his primary duty was to the panel.

The panel accepted the advice of the legal assessor. The legal assessor advised the panel to balance the unusual circumstances of this case with the ordinary rules that cover a witness in the course of giving evidence not having contact with their representatives.

The panel considered the possibility of the requested documentation being made available and you completing your oral evidence under oath within the last two remaining hearing days. The panel therefore decided to keep under review its decision on whether to release

you from your oath pending further information about the progress of the requested documentation from the Home.

On day nine of the proceedings, Mr Pleming informed the panel that the NMC had made some progress, but that the requested documentation had not been made available. He submitted that you should remain on oath in view of the possibility that some progress might be made by the last scheduled day of the hearing, which would allow for you to continue giving evidence. Mr Pleming submitted that there was a possibility for the factual evidence to conclude before the end of the last scheduled hearing day.

Mr Docherty submitted that you be released from your oath as he had not yet had the opportunity to speak with you since you started your oral evidence on day seven of these proceedings. He submitted that everything should be done to ensure that you complete your evidence by day 10 of these proceedings, so as to avoid the necessity for an undertaking, which would restrict your discussions with him, at all costs. Mr Docherty submitted that if an undertaking were to be made in the circumstances, this would be to your extreme prejudice.

The panel accepted the advice of the legal assessor.

The panel determined to you should remain on oath, with a view to resuming the hearing when more information was available. The panel decided to revisit this position if the documentation were not made available by 11:00 on day 10 of the proceedings.

Mr Pleming returned before the panel to provide a further update on obtaining the DATIX in respect of Patient 9 from the Home. This was an electronic form and did not give any clarity as to who had completed the DATIX or Patient 9’s full body check. Further, it was not clear that the DATIX in fact referred to Patient 9 at all. The Home had indicated that further patient records could not be sourced until after the remaining days of the hearing, but would be available thereafter.

The Chair noted that whilst some information had been made available, this was not enough in totality to proceed with the evidential stage of the hearing. It was likely to take weeks, rather than hours, to acquire the necessary documentation, a period which was beyond the allocated hearing dates. The Chair invited the parties to consider their positions on the matter of releasing you from the oath for the intervening period before the resuming hearing.

Mr Pleming and Mr Docherty maintained their positions on the matter.

The panel accepted the advice of the legal assessor.

The panel determined not to release you from the oath pending further information from the NMC by day 10 of the proceedings.

On day 10 of the proceedings, Mr Pleming provided the panel with new information concerning the patient records from the Hospital which had been before the panel. He provided the panel with additional documentation received from the Hospital in respect of the patient in room 1, bed 2. It was understood that this had been a reference to Patient 6, but the new documentation appeared to indicate that the occupant of that bed had a different name to the name which the panel had been given to understand referred to Patient 6. This was clearly unsatisfactory and called into question the integrity of the contemporaneous records. It was agreed that it was not satisfactory to proceed with further evidence until this matter had been clarified.

The Chair therefore released you from your oath and confirmed that you would now be able to speak to Mr Docherty in light of the new information about the documentary evidence in this case. The Chair noted Mr Docherty's ample assurances of his professional standards and duty to the panel and was satisfied that you would be guided by his knowledge and careful advice on what you can and cannot discuss with him.

The Chair made a direction that you must not talk about the progress of your case or evidence with anyone else except your legal representatives in the period before the resuming hearing. The Chair recognised the burden this might place on you and noted the support options that are available to you, but highlighted the seriousness of ensuring that this direction is adhered to. The panel apologised that your case had not concluded within the scheduled hearing dates and thanked you for your attendance and patience.

The hearing then adjourned.

Case Management Hearing on 5 July 2023

At the substantive hearing on 17 February 2023, the panel made the decision that it was unsatisfactory to proceed with the hearing until certain evidential matters had been clarified. The panel at the substantive hearing was particularly concerned about the completeness of the documentation which had been provided by the NMC in respect of the Patient 6 and Patient 9 for charges 2 and 7, respectively.

The substantive hearing is due to resume on 18 - 26 September 2023. The Notice of Hearing states that this hearing is being held for the panel to consider whether the NMC is planning to lodge more documentation.

The panel noted the charge particularised by the NMC.

The Chair clarified the issues outstanding and the directions made on 17 February 2023 and sought to know what had been done since then.

Mr Segovia, on behalf of the NMC, said that on 17 February 2023, some information was received but it appears that it was never presented to the panel. No further analysis has since been conducted and the significance never grasped. He submitted that it would appear to be the only information that the Hospital can provide. He clarified that the information will be looked at before the substantive hearing resumes in September 2023.

Mr Segovia said that after the information is analysed, the NMC might be able to confirm whether it can produce more information to the panel's satisfaction and meet the appropriate standard, and if it cannot, then it may offer no evidence.

Regarding the current position in respect of Patient 9, Mr Segovia said the Home is yet to provide all the information requested. In relation to Patient 9, he stated the DATIX before the panel is the only one available. Regarding the patient records for the 24-hour period following the incident from the Home, he stated the position is not clear as to the patient records for that period following the incident on the 12 February 2020.

Mr Weir informed the panel that he has taken over the handling of this matter until its conclusion. He said that he does not wish to be too critical of the NMC or the case presenter who dealt with the substantive hearing or the case presenter today, but it would not be his duty if he did not flag the serious concerns about how this case has been prepared to date which is unfair and causes prejudice to Mr Jamera. He informed the panel that his understanding of the hearing today was to address the issues with regards to the contemporaneous records before the NMC. The panel has been clear in its directions and from reading of the transcript what concerns they have and what steps could reasonably be taken to discharge its statutory duties and act fairly in the circumstances.

Mr Weir provided a brief background of the case. He said it was not clear when the investigation started since the interim order has been in place since 2021. Having reviewed the present situation, he submitted that it is unfortunate we are not further forward in the production of the documents. In the absence of the requested documentation, the panel are right to be concerned about what, if any weight can be attached to the evidence before them. Having had the benefit of the transcript, Mr Weir quoted the words of the Chair: '*It clearly places centrally the importance of contemporaneous documents and pushes us away from relying [on them] where there is likely to be documents on credibility or otherwise of witnesses that we find... we are left with the unenviable position of relying on witness evidence.*'

Mr Weir agreed with this assessment and said that five months down the line the documents requested have not been produced and it is most unlikely they will be produced. In light of this, he requested the panel to allow a no case to answer in relation to charges 1, 3, 4, 5 and 7. He submitted that the panel could competently hear such a submission under Rule 24 (7). He submitted that although, there is some evidence, when it is taken at its highest, it could not properly result in a fact being found proved.

Mr Weir said that procedurally the case is past the point where a no case to answer submission is normally made. He said he was not criticising anyone, but it is unusual for the panel to highlight serious deficiencies in the documentary evidence both at the start and throughout the hearing. He referenced the wording of the Rules and submitted that it provides for such an application at the conclusion of the Council's case. He accepted the situation is unusual due to the NMC's inadequate preparation of this case to date. He stated the panel can regulate its own procedure and have a duty to act fairly and ensure that proceedings are just to both parties. In the circumstances of this case, he submitted that it would give rise to a real miscarriage of justice if the request to make a no case to answer submission were refused. Mr Weir asked the panel to exercise their discretion and not apply too rigidly the terms of the Rule and ensure that proceedings are handled fairly in the circumstances of this case. He referred to the cases of *R v Home Secretary, ex parte Doody* [1994] 2 AC 531 and *Virdi v Law Society* [2010] EWCA Civ 100.

Mr Weir submitted that there was a reasonable expectation that the unredacted documents requested by panel on day one would have been produced before today. The absence of the documents casts serious doubt on what weight, the panel can place on the contemporaneous documents relating to charges 5, 6 and 7, which can also be resolved by the production of further records. He invited the panel to exercise its discretion and schedule a date to hear a submission of no case to answer and another case management hearing to resolve all outstanding matters. Furthermore, he stated that it would not be fair for Mr Jamera to be further cross examined in September on matters which remain unclear.

Mr Segovia in response said that Rule 24 (7) makes it clear when a no case to answer submission can be made. He submitted it is not a question of fairness because the point at which such an application can be made has passed. He said it would make no sense to hear the application because there is more evidence being sought. He submitted Mr Jamera should never have been questioned on evidence that was not clear in the first place.

In response Mr Weir submitted that what transpired during Mr Jamera's evidence is a significant issue and Mr Jamera is now in a position of giving evidence and responding to a case which is fundamentally flawed. Mr Weir repeated that he was blaming no one. He adopted the panel's words that it called into question the totality of the documentation relied upon significantly and that is a fundamental difference. He submitted there are deficiencies in the evidence and to imply the opportunity was not used when it came is procedurally unfair, bordering on an abuse of process.

Decision and reasons for directions given

In reaching his decision, the panel heard the advice of the legal assessor, who referred to Rule 24(7). The legal assessor told the panel that due to the unique circumstances of this case he was not able to give full and reasoned advice at this stage.

Since the committee has residual powers within the Rules to regulate its own proceedings, the panel can arrange for another case management hearing when full advice can be received encapsulating all the issues raised.

The panel, in considering this matter, gave careful consideration and had regard to the nature of the applications and took account of the submissions. This case management hearing was listed to resolve the outstanding issues raised at the substantive hearing. The panel had regard to the interests of justice, the efficiency of proceedings, and the fairness to both parties.

This panel reminded itself of the directions made at the substantive hearing. The NMC was to provide the following documentation:

- The panel directed the NMC to approach the Hospital and ascertain whether they could provide the original unredacted patient records, so that these documents could be cross-referenced and consequently ascribed to the patients contained in the charges. The panel noted its previous experience of a rapid turnaround of documents, particularly with NHS Scotland who have been efficient with assisting with past cases. The panel considered that it could be possible for these unredacted patient documents to be made available by day two (of those proceedings). It noted that the NMC witnesses who are still working at the Trust should be able to assist with this matter; otherwise, it should be sought from the Hospital. The panel determined that there were routes available to the NMC to source these documents without undue delay.

- All of Patient 6's records dated from 23 February 2018 up to and including 25 February 2018, and in particular, any notes, ward records or ward diaries about Patient 6 and any documentation regarding whether he should be put on end of life care from the Hospital; and

- The DATIX report relating to Patient 9's fall on 12 February 2020, as well as her patient records for the 24-hour period following the incident from the Home.

Having taken all the above into consideration, the panel made the following directions:

- Consideration of whether to hear a submission of no case to answer reserved until the hearing scheduled for September 2023.

- Case management hearing to be scheduled on 4 August 2023. On this day the NMC is required to clarify the evidence that supports the case against Mr Jamera.

- The NMC is to provide a full analysis and evidence matrix that supports each charge.

- Response on all directions previously made.

Case Management Hearing on 4 August 2023

The panel reconvened on 4 August 2023 for an update as to the directions it made on 5 July 2023.

Ms McGuinness, on behalf of the NMC, informed the panel that, in relation to the NMC obtaining all the evidence and as directed by the panel in the Substantive Hearing and the last Case Management Hearing, the obtaining of the documentation is not complete.

Ms McGuinness told the panel that she contacted the Case Co-ordinator today to indicate if a time scale could be given to the panel as to when the Hospital were contacted. She informed the panel that the Case Co-ordinator has advised her that the appropriate people who are in the position to source the information have been contacted and the information that has been requested may take some time. She informed the panel that the Hospital was emailed yesterday, which was 3 August 2023, seeking clarity.

In relation to Patient 9, Ms McGuinness informed the panel that the Home was contacted by the NMC in May and then again yesterday, 3 August 2023. So far, there has been no response. She said that it may be the view of the panel and of Mr Weir that further efforts should have been made by the NMC, given the hearing was adjourned in February. She said that it is acknowledged that more effort could have been made and perhaps prioritised, and that the panel, may find that unsatisfactory, particularly given the stage of the proceedings and any additional [PRIVATE] to Mr Jamera as a result. However, she said that the NMC's position, particularly in relation to Patient 6 is that the Hospital has received the clarification requests and these are now with the correct department.

Mr Weir, in response, said that this was unfortunate particularly as he made some fairly substantive and clear and submissions at the last hearing. He said that given the position that we were in and the expectation of what ought to have been happened, it was wholly unsatisfactory that these papers have not been chased until the day before this Case Management Hearing. As he understood the position to be, because the last hearing took place on 5 July 2023, it ought to have been reasonably clear that the information was to be provided today. He told the panel that this case has been in this unsatisfactory position since the substantive hearing and to have the Hospital and Home not been chased until yesterday is wholly unacceptable.

Mr Weir wished to renew his request to be allowed an opportunity to make a no case to answer submission. He said that this documentation has been requested since the last Case Management Hearing on 5 July 2023, and nothing further has come to light. He said that he has no confidence whatsoever that these papers will be produced before the substantive hearing resumes in September. He therefore urged the panel to take reasonable steps to try and address this situation today.

Ms McGuinness confirmed to the panel that the Home was chased up in May and then again on 3 August 2023 and the Hospital was emailed on 3 August 2023. However, she acknowledged that further efforts could have been made and priority given by the NMC in chasing this information. She said that it would not be fair to say that no efforts have been made, but it can be said that these efforts have been made very late, merely one day prior to this Case Management Hearing today.

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

Decision and reasons for directions given

The panel noted, despite the assurances supplied by Mr Segovia on the 5 July 2023, that there has been no further information or documentation received as the Home and the

Hospital were not contacted again until 3 August 2023, which was the day before this Case Management Hearing. The panel noted that the NMC made its initial requests for additional information in February 2023 and this did not lead to any relevant or significant additional information being provided. It was of the view that it should by now, have been foreseeable that the documentation was not likely to be made available within a 24-hour timeframe. The panel noted that its previous directions, made in July 2023, have not been acted upon until the 3 August 2023. This was far too late.

The panel make direction orders with serious intention that these directions are to be followed and all parties should abide by these. It is in the interest of justice to all parties that these matters are expedited and reported back to the panel.

In light of this, the panel directs that by 30 August 2023, the NMC lodge the responses received in answer to the directions given, alongside an up to date evidence matrix for its case failing which the NMC to confirm its position as to the status of their productions and case.

The hearing resumed on 18 September 2023

At the outset of the resuming hearing (day 11 of the proceedings), Ms Muir, on behalf of the NMC, introduced Patient 6's partially redacted patient records to the panel and indicated that these were the only new records that had been produced since the hearing last took place. Ms Muir indicated that she was aware that further documentation had been requested, but that the NMC had been unable to obtain any further documentation.

The panel considered Patient 6's partially redacted patient records and identified that the name in these records did not appear on the second version of the schedule of anonymity which had been produced at the initial hearing in February 2023. The panel also identified some inconsistencies between these records and the records attributed to Patient 6 at the initial sitting. The panel took into account that the charges in this case were particularised with specific patient identifiers. It considered that it was necessary to ensure clarity as to

whether these records and the records marked as Patients 1 to 5 actually related to the patients in the charges.

Mr Weir, on your behalf, renewed his application to allow a no case to answer submission to be made. He submitted that the NMC had been given several opportunities to comply with the panel's directions but still had not done so.

The panel considered that in order to consider whether it would be appropriate for it to consider a late submission of no case to answer, it first had to be clear what the NMC's case was against you. It therefore directed Ms Muir to provide an up to date evidence matrix and schedule of anonymity in order to be clear on what evidence presented in the case so far was now being relied upon and how it related to the charges. The panel was satisfied that this would provide the NMC with the opportunity to confirm its position in respect of the evidence in this case and provide fair notice to you.

Ms Muir indicated that it would take some time for her to do so, and undertook to produce an up to date evidence matrix and schedule of anonymity and present it to Mr Weir and the panel at 12:00 on day 13 of the proceedings.

On day 12 of the proceedings, Ms Muir provided the panel with unredacted NEWs charts for the patients purportedly in room 1 on 24 February 2018 and 25 February 2018. The panel noted that this document appeared to be an unredacted version of the records presented at the initial hearing in February 2023. The panel considered these records and identified that the names on these records bore no resemblance to the names provided in either the original or second versions of the schedule of anonymity. In the circumstances, the panel decided to allow Ms Muir the opportunity to conclude her production of the up to date schedule of anonymity and evidence matrix.

On day 14 of the proceedings, the hearing resumed following Ms Muir's presentation of the up to date evidence matrix and schedule of anonymity. The panel raised various concerns in respect of the documentary evidence which had been provided since the

outset of this resuming hearing. In the course of her submissions Ms Muir conceded that two of the patients (Patient 3 and Patient 5) had not in fact been present in room 1, which was the room particularised in the charge.

Decision and reasons on submissions on abuse of process

In light of the concerns identified relating to the provenance of the documentary evidence in this case, and the NMC's failure to comply with its earlier directions, the panel invited the parties to make submissions on whether there had been an abuse of process.

The panel was mindful of your desire to avoid any further delay in the progress of this case. However, it was of particular importance for the panel to assure itself that due process was being followed and that the integrity of these proceedings remained intact.

Mr Weir, on your behalf, asked the panel to consider his written submissions which stated:

> '*1. The Panel very fairly invited a submission on an abuse of process. I submit that there has been an abuse of process in this case. I invite the Panel on that basis to find none of the allegations proved and dismiss this case in its entirety.*
> *2. If the Panel is with me in my primary application then I submit they should also revoke the interim conditions of practice order with immediate effect,*
> *3. If the Panel is not with me in my primary application then I invite the panel to find allegations 1, 3, 4, 5 and 7 not proved.*
>
> *<u>The Law</u>*
>
> *4. I think it would be helpful for me to quote from Professional Regulatory and Disciplinary proceedings as to the law in this area. ['7.51 It is well established that abuse of process as a doctrine does apply to disciplinary cases. At common law, a tribunal has the jurisdiction to prevent its procedures from abuse: in appropriate cases, it may strike out or stay proceedings as an abuse of process.*

7.52 In circumstances where there cannot be a fair trial, or where the principle of fairness dictates that the respondent should not be tried, it may be appropriate for the matter to be stayed. The general test for whether proceedings amount to an abuse of process is whether prosecution/continuation would offend the Court's sense of justice and propriety. Abuse of process is a broad principle with no determined limits. The doctrine, and the grounds on which the proceedings may be stayed in Criminal proceedings, were summarised by Lord Dyson in R v Maxwell:

> *'It is well established that the court has the power to stay proceedings in two categories of case, namely (i) where it will be impossible to give the accused a fair trial, and (ii) where it offends the court's sense of justice and propriety to be asked to try the accused in the particular circumstances of the case. In the first category of case, if the court concludes that an accused cannot receive a fair trial, it will stay the proceedings without more. No question of the balancing of competing interests arises. In the second category of case, the court is concerned to protect the integrity of the criminal justice system. Here a stay will be granted where the court concludes that in all the circumstances a trial will offend the court's sense of justice and propriety (per Lord Lowry in R v Horseferry Road Magistrates' Court, Ex p Bennett [1994] 1 AC 42, 74g) or will undermine public confidence in the criminal justice system and bring it into disrepute (per Lord Steyn in R v Latif [1996] 1 WLR 104, 112f).*

7.53 The submission that proceedings should be stayed will always be approached with caution: such arguments add to the complexity of the trial process and where it would be possible to address the problem complained of at trial (eg the non-availability of evidence) a stay will not be warranted. Where assertions of abuse of process are put forward without justification, the courts are ready in appropriate cases to penalise the party concerned.]

5. In my submission abuse of process is fact and circumstance dependent and the conduct of the Regulator is an important consideration.

History of this case:

6. The Panel will be well aware of the procedural issues that have got us to this point in proceedings however I think it would be helpful if I can summarise very briefly how matters have progressed:

7. Mr Jamera was first referred to the NMC on 30 January 2019.

8. On 27 February 2019 an Interim Conditions of Practice Order was first imposed on the Mr Jamera' registration.

9. Following the imposition of the Interim Conditions of Practice Order, the NMC commenced its initial investigations with letters being sent to witnesses and correspondence entered into with the Respondent. Further correspondence was sent to the Respondent in August 2019 and to witnesses in September 2019. Due to the initial investigator leaving the organisation the investigation was handed over to a senior investigator in December 2019 who was unable to fully review the case until 9 January 2020 due to their high caseload. The senior investigator noted that further investigatory work was required. Delays to the investigation were encountered as a result of nonengagement of witnesses and difficulties in obtaining disclosure of information from the Home. The investigation was also delayed as a result of the Petitioner's investigation case work being paused between March and August 2020 due to the Covid-19 pandemic.

10. Following resumption of the investigation the Petitioner experienced further delays as a result of the difficulties with witness engagement.

11. The investigation was concluded in July 2021 and a copy of the investigation report along with the corresponding document bundle was sent to the Respondent. Following the statutory 28 day period for the Respondent to provide a response to the regulatory concerns the case was ready for consideration by the Case Examiners ("CEs") on 27 August 2021.

12. I mention this history simply to highlight that this is an investigation which has been going on substantively for 4 years.

13. On 23 March 2022, the CEs found that there was a case to answer and decided to refer the case to the Petitioner's Fitness to Practise Committee for adjudication. The case was allocated to a lawyer within the Petitioner's Case Preparation and Presentation department who reviewed the case and drafted charges. There was a further delay at this stage as due to high caseloads and competing priorities the review was not completed until 2 August 2022.

14. 11. A Case Management Form ("CMF") was sent to the Respondent on 23 August 2022 and he was afforded a 28 day period to complete and return it. The Petitioner received the completed CMF on 23 September 2022, in which the Respondent indicated that he wanted his case to be heard at a substantive hearing. The case was scheduled to be heard at a substantive hearing between 6 and 17 February 2023 however the panel of the Fitness To Practise Committee decided to adjourn the hearing due to further documentation and information being required in order to allow them to adjudicate the case. The case was listed for the substantive hearing to continue on 18 to 26 September 2023. Following a case management hearing on 4 August 2023 it was decided that further dates, in addition to the September dates, would require to be listed to continue and conclude the substantive hearing. These have been listed from 13 to 15 December 2023 taking into account the availability of the case parties and the Petitioner's hearing capacity. The Petitioner is currently in the process of obtaining the requested information and documentation.

15. I pause there to highlight that, despite there being 4 years with which the NMC could have properly obtained contemporaneous records, properly cross checked them with witnesses and properly prepared their case, significant issues came to light about the state of the papers offered in support of all of the allegations. What has transpired since in the NMC's handing of these matters in my submission is wholly unsatisfactory. It is a point I do not make lightly. I mean no criticism of the presenters with the following submissions but significant questions

must be asked about the NMC's procedures internally and whether anyone actually has any oversight to deal with these matters.

16. Firstly, there was a case management meeting in July which was sought by my colleague. At that hearing it was clear that the NMC did not seem to know what it was called for, no real thought had been given to what documents were to be produced and no substantive update was given. I asked to be allowed to make a NCTA submission and gave clear submissions on why that should be allowed. The decision on that was adjourned to August for legal advice and to give the NMC and opportunity to obtain papers. At that point we were 5 months from when the Panel first raised issues and approximately 4.5 years from when the investigation started.

17. The Panel could not have been clearer on what they expected. Which was full unredacted copies of all patient notes which were lodged and anonymised. Not unredacted NEWS scores or Datix's but full records. It was clear that this was needed so we could be satisfied that the papers produced and relied upon were what they purported to be.

18. By the time of the new case management meeting in August, a new case presenter appeared. They had no knowledge of why we were there, that my application to be allowed to make a NCTA submission was outstanding and no further progress had been made. In fact, it was not clear to me whether at that point the NMC had actually made their further request to the hospital let alone records having been produced.

19. One of the things specifically highlighted as part of that process by me and the chair was that we should not end up in a position whereby we start the hearing on 18th of September with these issues outstanding. Unfortunately that is exactly what has transpired.

20. The documents produced yesterday and today take us no further forward. The extensive confusion by everyone this morning speaks for itself. There is no clear indication as to which records relate to which Patient and therefore which allegation. The exercise this morning simply invited more questions than was answered.

21. I have concerns that even if admitted, where does it take us. No-one has spoken to the provenance of these documents. While witnesses have been questioned and cross examined these were on papers which have now been called into question significantly. The weight that can be applied at this stage is nil.

22. In turning to the anonymity keys – my submission is that whole process was simply put wholly unsatisfactory. What we essentially have is three different keys with no real clarity of which Patient is which and is based on guesswork and assumptions by the Panel, the now Presenter and whomsoever at the NMC has reviewed these.

<u>Application of the law to the facts of this case</u>

23. The key question I invite the Panel to consider is whether, in consideration of all that has transpired here, is it possible for Mr Jamera to get a fair trial. I say it is not for the following reasons:

a. Documents have not been fairly and appropriately disclosed.

b. Evidence has been led on documents which have been severely undermined since that evidence was adduced.

c. Identities of Patients who have been particularised have changed throughout these proceedings, largely as a result of guesswork.

d. The best indicator of where the truth lies is in what witnesses say and how consistent they are with contemporaneous records. We have no confidence that any of the contemporaneous records can be safely relied on. Therefore the Panel trying to make sense of these allegations is very difficult if not impossible.

e. This confusion is exacerbated in part by the attempts to resolve matters part way through the hearing. To give a practical example, we heard this morning that Patient 6 might actually be Patient 1 and that this is a moving feast depending on what day of the hearing you attended. That is significant. [Witness 3] in her witness statement for example talks about high NEWS sores for Patient 1 and at paragraph 13 that these had been "obviously added" for Patient 1. There is no charge that relates to retrospective additions to Patient 1. She was never asked with reference

to the anonymity key who Patient 6 was. You are now being asked to rely on her witness statement as evidence in support of a very serious allegation of dishonesty and the identity of that Patient is a moving feast.

f. These issues have come to light very late in the day and part way through Mr Jamera's cross examination. We are therefore in a situation whereby either the Panel allow these matters to proceed and he could be cross examined, potentially make prejudicial statements as a result of that, based on evidence which has been significantly criticised by the Panel. In my submission this situation cannot remotely result in a fair trial for Mr Jamera.

24. The authorities are clear that a stay of proceedings should be a last resort but in my submission, that threshold has been reached. The Panel tried to resolve these issues by allowing the NMC not one, not two, not even three but four opportunities if you include the attempts made this week to remedy this situation. That has not been complied with. There is no good reason for that. I submit that this is therefore a very clear abuse of process.

25. I invite the Panel to find none of the allegations proved on this basis and dismiss the case.

26. If you are not with me and consider that a fair hearing is still possible on the admitted allegations then I would simply invite the Panel to find allegations 1, 3, 4, 5 and 7 not proved and move on to stage 2 of the process.

27. If the Panel is not with me in my entirety then I invite the Panel to uphold my original request to make a substantive no case to answer submission on the evidence led to date.'

The panel then heard the submissions of Ms Muir. She submitted that she did not take any particular issue with Mr Weir's summary of the history of this case. Ms Muir submitted that the NMC had accepted that evidence (that is, the unredacted records for Patients 1 to 6) had been produced late, and that some of what had been requested by the panel at the initial hearing in February 2023 and the subsequent case management conferences in July and August 2023 had not been produced.

Ms Muir informed the panel that the documents she sought to admit into evidence (namely the unredacted NEWs charts for the patients in room 1) had been received by the NMC on 17 February 2023 in response to a request from the NMC to the Hospital, following a direction by the panel in February 2023. She submitted that there was no doubt that the NMC ought to have disclosed that information, and that the fact that it was not disclosed was something which appeared to have arisen due to error and confusion. Ms Muir submitted that there appeared to have been a belief that certain documents had been disclosed at the end of the initial hearing on 17 February 2023, when it was accepted that they had not been. Ms Muir accepted that further opportunities to disclose those documents were missed at the subsequent case management conferences in July and August 2023. She submitted that this was obviously unsatisfactory and stated that the NMC could only apologise to the panel, all parties and in particular, you for the issues that have arisen.

In relation to Mr Weir's submission on abuse of process, Ms Muir referred the panel to the NMC guidance on '*Abuse of Process*' (DMA-4) which states that an abuse of process application '*will only succeed if [the nurse, midwife or nursing associate] can show that it's more likely than not that the alleged abuse of process can't be properly rectified in any other way than to stop the case.*' Ms Muir acknowledged that you sought to have the entire case dismissed, but submitted that any issue could be rectified other than by stopping the case.

Ms Muir reminded the panel that your admissions to charges 2 and 6 had been made before the issues relating to documentary evidence during this hearing had arisen.

Ms Muir accepted that the alleged abuse of process related to a failure to supply records in relation to Patients 1 to 6, which had also caused issues in relation to the names on the schedule of anonymity for these patients. She submitted, however, that there was no abuse which would make it unfair to proceed with the charges.

Ms Muir submitted that the issues in this case related to Patients 1 to 6, and that charges 5 to 7 did not relate to those patients. She submitted that any issues with the evidence in relation to Patients 1 to 6 could not make it unfair to proceed with the charges relating to Patients 7, 8 and 9.

In relation to the evidence in respect of Patients 1 to 6, Ms Muir submitted that what the NMC had produced by way of unredacted NEWs records on day 11 did not amount to any new evidence as they had been exhibited before, albeit in a redacted form. Ms Muir submitted that as far as she was aware, there had never been any dispute raised that the records exhibited at the start of these proceedings in February 2023 were not what they bear to be. She submitted that there had been no dispute about the contents or accuracy of these records. Ms Muir submitted that the matters which were in dispute were:

- When these records were completed; and
- If they were not completed, why they were not completed; and
- Whether the reasons for not completing them were acceptable.

Ms Muir submitted that no documentary evidence would ever answer to these matters and that that evidence could only come from the witnesses. She submitted that these new records were not inconsistent with the evidence that had been given by the witnesses. Ms Muir asked the panel to consider Witness 1's live evidence on 7 February 2023 as an example of where she was asked about Patient 6 and referred to their patient notes. Ms Muir reminded the panel that Witness 1 had indicated that Patient 6 was the patient that had died, and she had also pointed out the NEWs score of '*7*' after examining the records. Ms Muir submitted that Witness 1 was not in any doubt as to who Patient 6 was.

Ms Muir submitted that the unredacted NEWs records provided the names of the patients in room 1 over 24/25 February 2018. She acknowledged that these records showed that the names on the second version of the schedule of anonymity were wrong, however it was her submission that this did not call into question the accuracy of the records which were referred to by the witnesses. Ms Muir submitted that this only called into question the

names of those patients, but that the names of the patients were not critical for this case. She submitted that none of the evidence depended on the patients having a particular name, and the witnesses were able to recall evidence and comment on the records without ever being shown a schedule of anonymity or being given the names of the patients.

Ms Muir submitted that at the start of the hearing, the NMC had presented charges against numbered patients using records which had patient numbers on them. She submitted that the NMC had made it clear which records related to which charges.

In relation to procedure and how the issues in this case might be dealt with, Ms Muir submitted that the hearing was at a stage where you were yet to conclude your oral evidence under cross-examination and re-examination. She submitted that allowing you to resume your oral evidence would provide further opportunity for you to challenge or disagree with the contents of the patient records.

Ms Muir stated that it had also been identified by the panel that some of the records in this case, namely the clinical notes, had not been verified as applying to particular patients. She submitted that the panel could determine what weight, if any, to attach to those records.

In relation to the records that were still missing, Ms Muir submitted that the fact that those records were not available, was not sufficient reason for this case to be stopped. She submitted that if the panel considered that the evidence before it was insufficient or unsatisfactory, then it could deal with that in its findings on the facts, or if a no case to answer submission were allowed and then made at that stage.

The panel accepted the advice of the legal assessor who referred to the NMC guidance on '*Abuse of Process*' (DMA-4) which sets out that:

'*The panel can decide there is an abuse of process if:*

- *it will be impossible for the nurse, midwife or nursing associate to have a fair hearing, or*
- *continuing with the case would, in all the circumstances, offend the panel's sense of 'justice and propriety'.'*

The legal assessor also reminded the panel that it had been aware of its duty 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 at the outset by its reference to the case of *Jozi* when it had made its initial directions.

The panel first considered charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1b)iii and 1b)iv which particularise Patients 1, 2, 3, 4 and 5. The panel noted that at the commencement of this hearing in February 2023, it had not been satisfied with the NMC's documentary evidence. This included the initial schedule of anonymity which indicated that Patients 1 to 6 were unknown. The NMC subsequently undertook further work and generated a second version of the schedule of anonymity which was substantially different to the first. At this resuming hearing, the panel was still concerned about the completeness and provenance of the NMC's documentary evidence and provided the NMC a further opportunity to address these concerns. Ms Muir produced a further schedule of anonymity which was substantially different to the first two versions.

The panel had made directions at the initial hearing in February 2023, but these had not been complied with. At the case management hearing in July 2023, the panel was informed that no further communications had been received from the Hospital after an email requesting documentation had been sent. Further directions were given at the two case management conferences in July and August 2023. However, at this resuming hearing, the panel was informed that the unredacted NEWs charts for the patients purportedly in room 1 had been provided to the NMC on 17 February 2023 during the initial dates retained for the hearing.

The panel was concerned that there was still documentary evidence before it, the provenance of which had still not been explained, and therefore determined that they could not be relied on. The panel had seen that the people identified as Patients 3 and 5 were not even in room 1 on 24/25 February 2018 and accordingly fell out with the ambit of charge 1. It was concerned that it had only been at its own insistence that an updated schedule of anonymity was produced, which was entirely different from the version produced in February 2023. That schedule had been part of the notice of the case you were facing and you could have reasonably have been expected to rely on it. That the position was only clarified within the present resuming hearing was further unfairness to you.

It was apparent that the NMC had additional documentary evidence (namely the unredacted NEWs charts for the patients purportedly in room 1) since February 2023, but had not disclosed this, as directed by the panel, and accordingly continued to advance its case on the basis of erroneous information as to the identities of the patients. The NMC's witnesses, during their live evidence, were taken to the observation charts of patients who had either been incorrectly particularised or were not even nursed in room 1 on the relevant dates. These witnesses were taken specifically to the charts provided by the NMC and asked to provide an opinion as to whether the observations were correctly completed within them. At no time were the witnesses able to identify any errors in relation to the identity of the patients to which the charts related. The panel was of the view that the witnesses had relied on the NMC's assertion that these charts related to the specific patients within room 1 as particularised in the schedule of anonymity.

The panel considered that as a fundamental aspect of these proceedings, you are entitled to fair notice of the charges that you face and the particularisation of the patients who appear in the schedule of anonymity. In particular, it noted that the NMC had interrupted your live evidence under cross-examination and raised the issues in regard to the integrity of its own documentary evidence. It was this revelation, properly made, which had been the reason that the hearing had to be interrupted in order to attempt to resolve matters. As

noted, the panel's directions had not been complied with and the issues had not been satisfactorily resolved.

The panel had considered recalling the witnesses and providing the NMC further opportunity to secure satisfactory documentary evidence in relation to these patients. However, it noted the history of non-compliance in this case and the information from Ms Muir that it seemed unlikely that the NMC would be able to gain any more information. The panel was also informed that some of the witnesses were unlikely to engage with these proceedings. In addition, the panel considered the witnesses' inability to identify the issues with the documentary evidence during their live evidence. The panel was not satisfied that it would be able to give sufficient weight to the relationship between the witnesses' oral evidence and the updated documentary evidence.

Having carefully considered the case in relation to Patients 1 to 5, the panel determined that, as a matter of practicality, it would be impossible for you to have a fair hearing in respect of charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1b)iii and 1b)iv.

The panel concluded that a well-informed observer or registered nurse would be concerned about whether continuing with the case would, in all the circumstances, offend their sense of '*justice and propriety*'. In all the circumstances, the panel determined that continuing with the case in respect of these patients would offend its sense of '*justice and propriety*'.

In light of the above, the panel decided to accept the abuse of process application in respect of charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1b)iii and 1b)iv, which related to Patients 1, 2, 3, 4 and 5. The panel was of the view that were it to proceed with these charges, trust and confidence in the NMC's role as a regulator would be undermined.

The panel further noted that pursuing charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1b)iii and 1b)iv would substantially increase the unfairness and unkindness to you

The panel next considered the case in relation to Patient 6, who had been particularised at charges 1b)v, 2, 3 and 4. The panel had not been provided with all the documentary evidence it had directed the NMC to obtain in February 2023. However, it had been presented with clear and detailed oral evidence in relation to Patient 6, which accorded with the clinical records attributed to them. Witness 1 had a clear recollection of Patient 6, and Witness 6 even had a personal connection with them.

In addition, the panel noted that you also recognised Patient 6 enough to make limited local admissions, make an admission at the outset of this hearing on charge 2, and then provide a clear recollection of the events relating to this patient in such of your oral evidence as has been heard, based on the clinical records presented.

The panel was not satisfied that the erroneous misattribution of Patient 6 to another named individual in the second anonymity schedule amounted to abuse of process such as would require charges 1b)v, 2, 3 and 4 to be stayed.

The panel then considered charges 5, 6 and 7 which related to Patients 7, 8 and 9. No direction had been made in respect of charges 5 or 6. The panel noted your admission to charge 6.

The panel had made a direction at the initial hearing in February 2023 in respect of charge 7, but this had not been complied with. The panel was disappointed that the requested documentation in respect of charge 7 had not been sufficiently pursued or produced by the NMC. However, it was not persuaded that this would be sufficient to amount to abuse of process.

In all the circumstances, the panel was not satisfied that abuse of process had been made out.

The panel therefore decided to reject the abuse of process application in respect of charges 1b)v, 2, 3, 4, 5, 6 and 7.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Muir on behalf of the NMC, and by Mr Weir 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 oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Senior Charge Nurse on the MAU at the Hospital at the relevant time;
- Witness 2: Clinical Lead Manager at the Home at the relevant time;
- Witness 3: Staff Nurse on the MAU at the Hospital at the relevant time;
- Witness 4: Staff Nurse on the MAU at the Hospital at the relevant time;
- Witness 5: Registered Manager of the Home at the relevant time; and

- Witness 6: Healthcare Support Worker on the MAU at the Hospital at the relevant time.

The panel also heard evidence from you under oath.

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 you.

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

Charge 1b)v

That you, a registered nurse:
At Borders General Hospital:

1. *On a night shift 24/25 February 2018 failed to complete a NEWS (National Early Warning Score) set of observations for the patients in Room 1 as follows:*
    b. *At 2am for:*
        v. *Patient 6.*

This charge is found proved.

In reaching this decision, the panel took into account the NHS Borders '*Clinical Observations Standard Operating Procedure*' document which stated that:

> '*All acute (non-elective) admissions should have a minimum of 4 hourly clinical observations for 48 hours from admission.*'

The panel had regard to Patient 6's '*Patient Unitary Patient Record*' which indicated that he was admitted onto the MAU on 23 February 2018 and therefore, four hourly observations would have been required.

Witness 1 confirmed in oral evidence that the '*Clinical Observations Standard Operating Procedure*' document was in place when Patient 6 was admitted onto the MAU. She stated that staff on the MAU were expected to conduct these observations as a "*baseline*" and if not, this would have to be clearly documented.

The panel also had regard to the two letters from Witness 1 dated 11 July 2016 and 10 October 2016. These letters were addressed to staff on the MAU, reminding them that:

> '*Every one of us has a contractual obligation to adhere to policies and guidelines developed by NHS Borders and this should always encompass patient safety and quality of care...*'

On this basis, the panel was satisfied that you had a duty to follow NHS Borders' guidelines and complete a NEWS set of observations every four hours, including at 02:00, for Patient 6 on the night shift of 24/25 February 2018.

In oral evidence you accepted that Patient 6's observations were to be carried out every four hours, including at 02:00. The panel reminded itself of Patient 6's NEWS chart, which included an entry under the 02:00 column for observations undertaken on 25 February 2018.

You stated that you did not undertake the observations at 02:00, but completed them a few minutes after 01:00. You stated that Witness 4 had asked you to take your break at 01:00, which was different to your usual break time of 02:00 so you took the observations before you went on your break. You said that you recorded the observations as having been completed at 02:00 because you had rounded the observation time up to the next hour. You told the panel that this "*leeway*" was allowed under usual ward practice, and

that anyone reading the patient records would have expected that the observations took place between 01:00 and 02:00.

The panel noted your acceptance that you did not undertake Patient 6's NEWS set of observations at 02:00 on 24/25 February 2018, as you had done so at 01:00 instead.

The panel did not accept your account about the "*leeway*" as in the panel's view, this was too large a gap. The panel accepted that there would need to be some leeway as not all of the observations for all patients could be completed on the hour, however the panel considered that as you had completed the observations at a few minutes after 01:00, it would have been more reasonable to record them as 01:00 observations rather than 02:00.

The panel took into account the purpose behind four-hourly NEWS observations, which includes a timely reassessment of the patient's condition. The panel determined that such a timely reassessment of the patient would normally be documented contemporaneously with an accurate time attributed to them. The panel determined that attributing observations taken just after 01:00 to 02:00 was too remote to be considered accurate for the purposes of documenting NEWS observations. The panel noted that you would have been in the knowledge that you would be back from your break at 02:00 and therefore able to complete the observations on time. Therefore, the panel considered that it would not have been unreasonable for you to complete a further set of observations at 02:00 to comply with the document for Patient 6, given the high NEWS score. However, you did not do so.

Having found that you had a duty to undertake Patient 6's NEWS set of observations at 02:00 on 24/25 February 2018, but did not do so at that time, the panel therefore determined, on the balance of probabilities, charge 1b)v proved.

Charge 3

That you, a registered nurse:
At Borders General Hospital:

3. *Made a record of a 2am NEWS score of 7 retrospectively on the NEWS chart for Patient 6 for 25 February 2018.*

This charge is found NOT proved.

In reaching this decision, the panel accepted that you had completed Patient 6's observations just after 01:00, rather than at 02:00 as required. It noted that a NEWS score of '*7*' was recorded under the 02:00 column on Patient 6's NEWS chart on 23 February 2018.

The panel noted Witness 3's written statement dated 9 February 2023 which stated:

> *'At around 4am I was sat at the nurses' station with [Witness 4] when Israel came over with the NEWS chart in his hand and asked [Witness 4] why the observations for room 1 hadn't been done. I quite clearly remember her saying "I told you Israel I done room 2 and you'd to do room 1 and the side rooms". Israel was silent for what felt like a long pause, he seemed to be processing what she had said, and then he just said "Okay I'll catch up". He didn't say why he hadn't done them, but I remember [Witness 4] was worried because they were then around two hours late.'*

The panel had heard evidence from Witness 6 that Patient 6's health deteriorated during the night shift on 24/25 February 2023 and he had talked to you about Patient 6's condition at 02:00 and 06:00 and escalated his concerns to Witness 4 at about 05:00.

However, there was no evidence before the panel to suggest that any one had reviewed Patient 6's NEWS chart between 01:00 on 25 February 2019 and 26 February 2023 during the audit of patient records after he died. There was no direct evidence before the panel,

aside from the evidence of your conversation with Witness 4, to support the allegation that the observations attributed to 02:00 on Patient 6's charts were not on the charts at 02:00 that night. The panel did not consider that the only natural inference from your discussion with Witness 4 was that the observations for Patient 6 had not been completed by 02:00 and that they had therefore been retrospectively added. Additionally, this issue was also explored during the internal investigation meeting conducted by Witness 1. While only Witness 6 said he did not see the observations recorded, none of the other witnesses said that they had seen Patient 6's NEWS chart during the night shift, despite being asked directly about this. During his oral evidence, Witness 6 said that he had not seen any NEWS chart during the night shift.

Accordingly, the panel could not be confident that, on the balance of probabilities, you made the record of the 02:00 NEWS score of '7' on Patient 6's chart retrospectively. The panel therefore found charge 3 not proved.

Charge 4

That you, a registered nurse:
At Borders General Hospital:

4. *Your action at 3 was dishonest in that you intended to mislead any reader of the NEWS chart that you had carried out a complete NEWS set of observations around 2am on 25 February 2018 when you knew you had not done so.*

This charge is found NOT proved.

Having found charge 3 not proved, the panel did not find dishonesty in respect of this charge. It therefore found charge 4 not proved.

Charge 5

In relation to charges 5a, 5b and 5c, the panel had regard to an extract from Patient 7's patient notes, which included entries made by you on 7 February 2020 at 14:00 of the patient's observations and a pulse rate of 36. It also stated '*will take obs in 2hrs time*'. There was no written record in Patient 7's notes indicating that you had subsequently escalated this pulse rate, that you sought a second opinion, or that you had taken a full set of observations.

The panel also noted Witness 5's written statement dated 25 May 2021 which stated:

> '*On 7 February 2020 Israel recorded an extremely low pulse of 36 in [Patient 7's] notes.*
>
> *I discovered this several days later because I was checking Israel's work following another incident, and I was concerned because he did not appear to have taken any action in relation to this. He had written in the notes that he would check Patient 7's observations again in two hours however there was no evidence that he had done this. I questioned Israel about this and he said that he thought maybe Patient 7 was just a very fit man and had perhaps been an athlete when he was younger. I asked if he had read the notes to check for underlying conditions and he said no. I would have expected him to check Patient 7's notes to see if there was a reason why his pulse so low, and seek a second opinion from colleagues or escalate this. This was a resident who needed a pacemaker so this was a normal pulse for this person in his circumstances, but for any other patient this would have been seriously concerning and any nurse should know this. This could have indicated a cardiac issue or the patient requiring hospital admission and they could have potentially died in these circumstances so Israel ought to have taken some action to find out the cause of such a low pulse. There were plenty of other professionals in the building including myself and the clinical lead on shift who he could have spoken to about this.*'

Charge 5a

That you, a registered nurse:
At Drummohr Care Home:

5. *On 7 February 2020 after recording a pulse rate of 36 for patient 7:*
    a. *Failed to escalate the patients care, and/or*

This charge is found proved.

In reaching this decision, the panel took into account your entry in Patient 7's notes on 7 February 2020.

The panel considered that it was basic nursing knowledge that a pulse rate of 36 was exceptionally lower than a normal pulse rate, and you therefore had a duty to escalate Patient 7's care.

The panel noted Witness 5's evidence that she would have expected you to escalate Patient 7's care after recording a pulse rate of 36. In oral evidence she confirmed that you did not escalate this.

You told the panel in oral evidence that you had no knowledge of Patient 7's history and you did not have their observation charts at the time, so you did not know whether the pulse rate you had recorded was within normal limits for the patient. You stated that you did not escalate Patient 7's care after recording the pulse rate because matters immediately escalated out of your control as Witness 5 had called you into her office before you had an opportunity to do so and before you had left the patient.

The panel took into account your acceptance that you did not escalate Patient 7's care after recording a pulse rate of 36 because you were immediately called into Witness 5's office. You were unable to give an account as to how Witness 5 would have known that

you had just taken Patient 7's observations and recorded a pulse rate of 36. The panel preferred Witness 5's evidence that she had spoken with you about Patient 7's pulse some days later. The panel found Witness 5's evidence plausible, consistent and reliable.

The panel therefore found, on the balance of probabilities, that at Drummohr Care Home on 7 February 2020 after recording a pulse rate of 36 for patient 7, you failed to escalate the patient's care.

Charge 5b

That you, a registered nurse:
At Drummohr Care Home:

5. *On 7 February 2020 after recording a pulse rate of 36 for patient 7:*
    b. *Failed to seek a second opinion, and/or*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 5's written statement in which she differentiated between escalating Patient 7's care and seeking a second opinion. The panel took the view that the ordinary meaning of seeking a second opinion in this context focussed around whether the recording itself was inaccurate or whether the practitioner had some difficulty in taking the reading. There was no evidence before the panel to suggest that the pulse rate you recorded was inaccurate or that you had some difficulty in taking Patient 7's pulse rate on 7 February 2020.

The panel was therefore not satisfied that, as a registered nurse, you had a duty to obtain a second opinion, in the absence of any difficulty in taking Patient 7's pulse rate or of any ambiguity of the actual pulse rate. The panel found charge 5b not proved.

Charge 5c

That you, a registered nurse:
At Drummohr Care Home:

5. *On 7 February 2020 after recording a pulse rate of 36 for patient 7:*
    c. *Failed to take a full set of observations within 2 hours.*

This charge is found proved.

In reaching this decision, the panel took into account your evidence and that of Witness 5, that at the time of taking Patient 7's observations, you did not know the patient's medical history and so you did not know whether a pulse rate of 36 was alarming for this patient.

The panel noted the entry that you '*will take obs in 2hrs time*' in the patient notes. It considered that by making this entry, you placed upon yourself a duty to take Patient 7's observations again two hours later. Despite having made this entry, there was no evidence in the patient notes that you did so.

During her oral evidence, Witness 5 was taken to Patient 7's notes and she confirmed the lack of subsequent observations following your initial observations on 7 February 2020 at 14:00. Witness 5 told the panel that it was unacceptable not to record the reason for the lack of follow-on observations in the patient's notes, even if you had discovered that it was not necessary to do so in Patient 7's case. She stated that a note should have been made, but there was no such note in the records.

The panel had regard to your evidence that you had intended to repeat the observations within two hours had you had time to do so. However, you had not done the observations within those two hours.

The panel therefore determined charge 5c proved on the balance of probabilities.

Charge 7a

That you, a registered nurse:
At Drummohr Care Home:

7. *On 12 February 2020:*
    a. *Failed to respond promptly to an emergency alarm.*

This charge is found proved.

In reaching this decision, the panel considered the ordinary meaning of the word '*promptly*', that is, to attend to with some urgency.

The panel noted that you were the nurse in charge on the upper floor of the Home on 12 February 2020. There was therefore an expectation that you would respond to emergency alarms in a prompt manner. This was confirmed in evidence by Witness 5 and Witness 2. The panel considered that whilst there was a duty on all members of staff at the Home to respond to the emergency alarm, this did not lessen the responsibility you had as the nurse in charge on the floor to respond to the alarm promptly.

Witness 2's written statement dated 14 May 2021 stated:

> '*On 12 February 2020, an emergency alarm was activated on the upper floor, which Israel did not respond to. I went up to see what was going on and there was a lady lying on the floor in the corridor, she had a fall. I couldn't see Israel so I asked the other staff and they didn't know where he was. After about 2-3 minutes he then appeared. Although this doesn't seem like a long time, we expect an emergency alarm to be answered within seconds. I asked where he was and he advised he was doing a dressing on another resident. I told him you should make the resident safe and come to the, emergency straight away.*'

Witness 2's oral evidence was consistent with the account that whilst working on the ground floor, she heard the emergency alarm going off on the upper floor for some minutes before attending the incident where, on her arrival, you were not present with the patient. Witness 2 maintained in evidence that it was only after her arrival that you appeared.

Witness 2 told the panel that it would take her 10 to 15 seconds to respond to an emergency alarm, whilst Witness 5 stated that she would run immediately to the incident if she heard an emergency alarm. The panel was satisfied with the evidence that you should have responded to the emergency alarm on your floor straightaway.

Witness 5's written statement dated 25 May 2023 stated that:

> '*Emergency alarms are used to alert staff to resident emergencies; Israel would not have known what the situation was without personally going to check. An emergency alarm can mean that a resident has been seriously injured or is in a critical condition, for instance requiring resuscitation. Obviously Israel had to make sure the resident he was working with was safe before he left them, but he was doing a foot dressing so the resident would have been sitting down and wouldn't be leaving them at risk in this situation.*'

You told the panel in oral evidence that when the emergency alarm went off, you were doing a patient's foot dressing. You said that this patient was leaning forward in their wheelchair and so you felt it necessary to ensure that this patient was seated in a comfortable and safe position before leaving to attend to the emergency alarm. However you also accepted that it should have only taken you a few seconds to ensure that the patient was safely seated on the wheelchair before attending to the emergency alarm. You were unable to explain why this process took you some minutes.

The panel was not satisfied that the patient could not have been safely in the wheelchair if you had left to respond to the emergency alarm promptly, as you had suggested. The

panel considered that even by your own account, it should not have taken several minutes for you to make the patient you were attending to safe in their wheelchair or call for someone else to supervise that patient before responding to the emergency alarm.

On the basis of the evidence, the panel was satisfied that you did not respond to what was an unknown emergency at the time, promptly. It therefore found charge 7a proved.

Charge 7b

That you, a registered nurse:
At Drummohr Care Home:

7. *On 12 February 2020:*
    b. *After Patient 9 fell to the floor failed to conduct a full body check.*

This charge is found NOT proved.

In reaching this decision, the panel noted Witness 2's account that she had gone up to see what was going on after the emergency alarm was activated on the upper floor of the Home, and saw a resident who had had a fall lying on the floor in the corridor. Witness 2's evidence was that you did not respond to the emergency alarm until after about two to three minutes.

Witness 2 told the panel in oral evidence that she had conducted a full body check on Patient 9, but that she did not tell you that she had already done this when you arrived.

The panel accepted the evidence that Witness 2 was at the scene of Patient 9's fall before you got there. It considered that as a registered nurse, she had the duty to respond to the situation on her arrival as she had arrived at the incident first. The panel would have been assisted with the contemporaneous records of the incident, which would have included the DATIX form mentioned by Witness 2. However, the panel accepted the evidence that she had already conducted a full body check before you had arrived at the incident.

The panel found that there was no duty on you to conduct Patient 9's full body check after they fell to the floor because Witness 2's had already dealt with the fall as the first registered nurse at the scene of the incident.

It therefore found charge 7b not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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

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.'*

Ms Muir invited the panel to take the view that the facts found proved amount to misconduct. She submitted that these charges were serious, relating to failure to escalate patients, failure to respond to an emergency alarm, failures regarding the observation of patients and failures in relation to record keeping with regard to medication administration.

Ms Muir then referred the panel to the areas of the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) which, in her submission, you had breached.

Mr Weir asked the panel to consider the case of *R(Remedy UK Limited) v General Medical Council* [2010] EWHC 1245, and the NMC guidance on misconduct. He submitted that not every breach of the Code will amount to misconduct, and asked the panel to consider whether the facts found proved are not only enough to breach the Code, but significant enough to amount to serious professional misconduct. Mr Weir submitted that mere negligence is not sufficient, and that a mistake in clinical judgement on one occasion is not serious enough to meet the test of misconduct in the circumstances.

Mr Weir addressed the panel in respect of each of the charges which had been found proved. He referred to the contextual context within which these matters arose and submitted that your conduct at each of these charges did not amount to serious professional misconduct.

Mr Weir submitted that there were two blocks of issues with your clinical practice:

- One set of allegations relating to one particularly challenging shift in February 2019 when, in part, the errors that occurred were contributed due to you being asked to take a break outside of your normal routine and where there was a miscommunication between colleagues.
- The second set of allegations relating to two instances over the course of a very short period of time when you were still getting used to a new work environment.

Mr Weir submitted that individually and collectively, the behaviour found proved, while regrettable and clearly mistakes, did not breach the threshold for serious professional misconduct of a kind referred to in both the case law and the NMC guidance. He therefore invited the panel to find that your behaviour did not amount to misconduct, and to take no further action.

Submissions on impairment

Ms Muir moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Muir submitted that your conduct is capable of being remediated. She submitted that it was a matter for the panel to determine whether the issues have been remedied based on the evidence you have submitted.

Ms Muir submitted that it was relevant to consider your insight. She submitted that whilst two of the charges were admitted, charges 1b)v, 5a, 5c, and 7a were denied. Ms Muir referred to your reflective statement in which, she submitted, you have reflected on your conduct with the benefit of the panel's comments in its determination on facts. She then referred to your training certificates and asked the panel to consider whether these adequately address the areas of concern. Ms Muir submitted that the training you completed in 2021 appeared to be more generalised and did not focus on the particular areas of concern. She highlighted that training in the administration of medicines was undertaken at the end of February 2020 after the charges relating to the Home, whilst the rest of the training pre-dated the charges.

Ms Muir submitted that you have not been working as a nurse since you left the Home and so you have not demonstrated improved practice. She submitted that there is a risk of repetition. Ms Muir submitted that the charges relate to events in 2018 and 2020, where issues with escalation and observations were repeated. She submitted that they were not one-off incidents, and she further highlighted that charges 5a, 5c, 6 and 7a occurred whilst you were on a performance improvement plan at the Home.

In conclusion, Ms Muir submitted that the charges in this case are serious and that your conduct put patients at risk of harm. She submitted that in order to protect the public, satisfy the collective need to maintain confidence in the profession, as well as declaring and upholding proper standards of conduct and behaviour, a finding of current impairment on both public protection and public interest grounds is necessary.

Mr Weir stated that you have been allowed to practise as a nurse under interim conditions of practice for a number of years since the last incident took place. He submitted that this restriction on your practice has made it difficult for you to secure employment and you have not held a substantive nursing role since you left the Home. However, in his submission, there have been no other issues with your character since the incident.

Mr Weir submitted that the conduct is easily remediable as they all relate to issues of clinical practice over two different, very short instances, some time apart and some time ago. He submitted that you have fully engaged with this process with the utmost of openness and truthfulness, and that whilst you have denied allegations, that should not be taken as an indication that you do not understand how to remedy the issues found proved. Mr Weir submitted that you admitted to some of the allegations at an early stage and offered insight and reflection into your practice.

In relation to your reflective statement dated 12 December 2023, Mr Weir asked the panel to consider your extensive engagement and attempts to offer ongoing insight and reflection as this process has evolved. He invited the panel to commend you for taking a

step back, considering the different view points and offering additional insight and reflection, which in his submission is indicative of someone that is always keen to reflect on any incident, understand why things were done, what went wrong and look to how they can continually improve in the future.

In relation to whether your conduct has been remedied, Mr Weir referred to your engagement with the process, your oral evidence, written reflections and evidence of further training. He submitted that you have learnt significantly since the incidents took place, and that the panel can be assured that no incidents of that nature are likely to reoccur. Mr Weir submitted that the misconduct is highly unlikely to be repeated.

Mr Weir provided a background of your nursing practice. He submitted that you have a long distinguished career in the nursing profession and that this is the first time any concerns have been raised about your practice.

Mr Weir submitted that there is no ongoing risk to the public through repetition of these clinical mistakes and as such, a finding of current impairment is not necessary to protect the public. Mr Weir submitted that a finding of current impairment is also not in the public interest. He submitted that a reasonably informed member of the public in full possession of all of the facts of the charges found proved, the insight, reflection and evidence of training provided, would be satisfied that no further action is required by the NMC. He submitted that the reputation of the nursing profession and the NMC as an effective regulator would not be damaged in the eyes of the public with a finding of no current impairment in this case.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Ronald Jack Cohen v General Medical Council* and *CHRE v NMC and Grant*.

Decision and reasons on misconduct

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

The panel was of the view that 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. In particular:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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:

10.2 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

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered the charges which had been found proved, namely charges 1b)v, 2a, 2b, 5a, 5c, 6 and 7a.

In relation to charge 1b)v, the panel had found that after you took Patient 6's observations at 01:00, it would not have been unreasonable for you to complete a further set of observations at 02:00 to comply with the requirement set out on the NEWS chart, in the standard operating procedure (SOP) and in view of the patient's NEWS score. The panel accepted that Patient 6 was on end of life care and already scoring a high NEWS score upon arrival at the MAU. However it considered Witness 3's written evidence that:

'*Not doing observations frequently enough for the patients on the MAU is risky because you could miss deterioration in any of their vital signs... If they are becoming more unwell we check them more frequently. A lot can change in four hours for these patients so being two hours late with observations could have a big*

impact on their health if we've not been able to see changes and decide on what treatment is needed.'

The panel considered your experience in working with patients who are ill, deteriorating or at the end of their lives on an MAU and noted that you would have been fully aware of your responsibilities in respect of NEWS monitoring intervals with patients at the end of their lives.

The panel noted your reflection that you thought you were taking the initiative, in the best interest of the patient, by taking the observations at 01:00. It considered, however, that by only taking observations at 01:00, there was a risk that this could have led to a five to six hour gap in Patient 6's observations, particularly if a similar '*leeway*' approach was applied for the next observation. In the panel's view, this was unacceptable and related directly to patient safety. On this basis, the panel found that your actions at charge 1b)v fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

In respect of charges 2a and 2b, the panel had heard evidence that Patient 6's condition had been deteriorating during the night shift of 24/25 February 2018. Witness 6 had told the panel that he spoke to you at around 02:00 and then later on at 04:45 as he was concerned about Patient 6's condition. He later spoke to Witness 4, who was working on a different area of the ward as he was still worried about Patient 6's condition. The panel considered that whilst Patient 6 was on end of life care, it was still important for their condition to be escalated to the Shift Coordinator and/or the HAN Team to ensure that an appropriate treatment plan was in place. The panel also had regard to Patient 6's NEWS chart which clearly stipulated that a NEWS score of 7 or more, would require an immediate assessment by the nurse in charge, and escalation to the Consultant Registrar, Ward Doctor and Outreach Team/HAN. The panel considered that by failing to escalate Patient 6's care, you risked compromising the care Patient 6 received at the end of their life. It therefore found that your actions at charges 2a and 2b fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Regarding charges 5a and 5c, the panel noted that a pulse rate of 36 was, at the time, normal for Patient 7 as he was awaiting the placement of a pacemaker. However, you had no knowledge of Patient 7's history when you recorded their pulse rate because you did not check their observation charts. Witness 5's written evidence was that whilst this pulse rate was normal for Patient 7 in the circumstances, for any other patient this would have been seriously concerning and could have indicated a cardiac issue or the patient requiring hospital admission, and they could have potentially died in these circumstances. Since you were not aware of Patient 7's history, the panel considered that your failure to escalate Patient 7's care and then take a full set of observations within two hours could have put them at risk of harm because you did not fully assess this patient to determine whether you should have been alarmed by that reading. The panel found that your actions at charges 5a and 5c fell seriously short of the conduct and standards expected of a registered nurse and accordingly amounted to misconduct.

On charge 6, the panel noted Witness 5's written evidence that:

> *'When I questioned Israel he told me he gave the diazepam to Patient 8 for stomach pain. Diazepam is prescribed for agitation, not pain relief. When I put this to him he said he gave it with paracetamol to relax the [abdominal] muscles. It was concerning that he would give his medicine four days in a row without getting a second opinion or looking further into why the resident was in pain.'*

However, in your written reflection you told the panel that you administered this medication to Patient 8 for anxiety he developed after an assault at the Home. The panel considered that had this been the case, this was a significant development in Patient 8's condition that should have been recorded. In the panel's view, your conduct was serious because you administered Diazepam four days in a row for a change in presentation which should have been documented, but had not been. The panel considered that it would have been reasonable to document this on Patient 8's MAR chart, and if not, elsewhere in the patient notes, but there was no evidence to suggest that it had been recorded at all, nor had you

pointed to such an entry during the local investigation. The panel noted that you had received induction training, specific training on medication management and had worked at the Home for a significant period of time prior to these events. The panel therefore considered that you would have been familiar with the MAR charts and the policies and procedures of the Home in relation to the administration of 'as required' medication and how the administration of these were to be recorded. It therefore found your actions at charge 6 fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

In relation to charge 7, the panel did not accept Mr Weir's submission that it was just a patient's buzzer. The panel had heard evidence that the emergency alarms went off frequently at the Home. However, it was satisfied that staff were expected to respond to them immediately and you had received training to that effect. You were nurse in charge of and the only nurse on the upper floor, so you would have been expected to respond to the emergency alarm promptly, yet it was Witness 2 who came from downstairs to do so. The panel accepted that at the time, you were attending to a resident's foot dressing, which was not a procedure that could not be interrupted and in the circumstances of this alarm, you did not have any knowledge regarding the potential seriousness of the situation to which this alarm related. The panel was of the view that five minutes was too long of a response time to an emergency call that could have been extremely serious which could have put the patient at risk of harm. The panel was of the view that you did not prioritise the emergency alarm over a routine procedure and failed to take appropriate action as the nurse in charge. The panel was therefore satisfied that your actions at charge 7 fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of your 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. To justify that trust, nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) …'

The panel determined that limbs a), b) and c) are engaged in this case. It found that patients were put at unwarranted risk of harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the nursing profession and has brought its reputation into disrepute.

The panel considered that within these regulatory concerns, there were recurring themes around prioritising and attending to patients who needed urgent care, managing/escalating urgent situations, and collaborating and communicating with colleagues to provide patient care.

The panel recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether you would pose a risk of repeating the misconduct in the future.

The panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* and whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future.

Regarding insight, the panel had regard to your reflective piece dated 12 December 2023, in which you addressed each of the charges in light of the panel's findings on the facts. It noted that you had made admissions to some of the charges and demonstrated an understanding of how your actions put patients at a risk of harm. You also demonstrated some remorse and indicated how you would handle the situations differently in the future. However, there was no reflection on how your actions impacted negatively on the

reputation of the nursing profession. The panel therefore found that your insight into your failings was developing, but did not fully address all of the regulatory concerns.

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. You provided training certificates dated between 30 January 2020 and 20 April 2023, some of which were broadly related to the areas of regulatory concerns. The panel noted that only the module '*Conflict resolution*' completed on 9 May 2021 could be said to be directly related to improving collaboration and communication within teams.

The panel also noted the certificate of competence in '*Acute Illness Management*' from NHS Borders with a score of 92% completed on 15 March 2018. However, it noted that this particular training pre-dated the incidents in 2020. The panel determined that the regulatory concerns within the charges found proved in 2018 were present in the charges found proved in 2020 at the Home. Accordingly, the panel placed limited weight on this training. In addition, the panel had not seen sufficient evidence of training which addresses the recurring themes the panel had identified.

The panel also had regard to your probationary review form from the Home dated 30 January 2020 which commented that you are an enthusiastic nurse who is reliable, but highlighted that there was a need for development in various areas of your practice, including leadership, patient (resident) assessment and teamwork.

The panel took into account that you have been subject to an interim conditions of practice order, which has made it difficult for you to secure a substantive nursing role since you left the Home. The panel noted that you have not been working as a registered nurse and therefore have not been able to demonstrate strengthened practice as a registered nurse. However, it considered that working as a registered nurse is not the only way you can demonstrate a strengthening of your practice and there is no evidence before the panel that demonstrates your practice has been strengthened.

The panel was not satisfied that it was highly unlikely that your conduct would be repeated in the future, nor was it satisfied that you can currently practise safely, kindly and professionally. On this basis, the panel found that there is a risk of repetition and that a finding of current impairment of fitness to practise 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 required because you put patients at risk of harm through your misconduct. The panel considered that a well-informed member of the public would be concerned if a finding of impairment were not made to mark the public interest.

In addition, the panel concluded that public confidence in the profession and the NMC as a regulator would be undermined if a finding of impairment were not made in this case which concerned failures around prioritising care and escalating concerns. It therefore also found 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 on public protection and public interest grounds.

Sanction

The panel considered this case very carefully and 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 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.

Submissions on sanction

In the Notice of Hearing, dated 14 December 2022, the NMC had advised you that it would seek the imposition of a suspension order for a period of four months with review, if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submitted that a conditions of practice order is appropriate in light of the panel's findings.

Ms Muir submitted that a conditions of practice order which deals with the regulatory concerns identified by the panel would protect the public and meet the public interest. She submitted that the regulatory concerns in this case are too serious to take no action or impose a caution order.

Ms Muir highlighted the panel's finding that your insight is lacking in relation to the impact on the reputation of the nursing profession, but that it is developing. She submitted that if the panel were particularly concerned about your limited insight, it might consider a suspension order. However, in Ms Muir's submission, a conditions of practice order would adequately protect the public and mark the public interest in this case.

The panel also bore in mind Mr Weir's submissions. Mr Weir invited the panel to impose no order. He acknowledged that this was a relatively rare approach, but submitted that it would be proportionate and appropriate in this case. Mr Weir submitted that there was an absence of significant aggravating factors and a number of mitigating factors in your favour, including a long work history, the length of time since the incidents occurred,

insight and reflection, and training that has been undertaken. Mr Weir submitted that your return to the workforce would necessitate a period of probation and supervision which will address the specific gaps highlighted by the panel.

Mr Weir submitted that if the panel was not minded to take no action, then it should consider whether a caution order would be sufficient. Mr Weir submitted that if the panel was not of the same view, then it should impose no more than a conditions of practice order. He reminded the panel that you are not working as a nurse because the current interim conditions of practice have been a barrier to you securing employment. Mr Weir submitted that any conditions of practice imposed should be for some specific focussed training to address the specific issues found by the panel, and limited to those where your current training has not gone far enough to satisfy the panel that the misconduct has been remedied. He submitted that a period of training with a reflective account would remedy the gaps as identified in the panel's decision on impairment.

Mr Weir submitted that it was your respectful request that any such conditions are formulated in a way so that they do not become a barrier to you securing employment as a registered nurse. He submitted that no further conditions would be necessary or proportionate. He referred the panel to a recent NMC Fitness to Practise case where similar charges were found proved, and where suitable conditions of practice were deemed to balance the need to remedy the behaviour against the impact on the registrant in that case.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your conduct put patients at risk of harm.
- There was more than one episode of misconduct which took place in 2018 and then again in 2020, despite the training you had completed in the intervening period.
- Your level of insight has not been fully developed.

The panel also took into account the following mitigating features:

- You have demonstrated developing insight and continued reflection.
- There is no evidence of a deep-seated attitudinal problem.
- You have made attempts to strengthen your practice through the completion of a number of training courses.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the regulatory concerns. The panel decided that as there would be no restriction on your practice, 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 but again determined that, due to the seriousness of the regulatory concerns and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order is only appropriate '*if the Fitness to Practise Committee has decided there's no risk to the public or to patients requiring the nurse, midwife or nursing associate's practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise committee wants 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, in particular a continued requirement for public protection. 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 was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, and identified the following factors in your case:

- *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;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate workable, appropriate and practical conditions which would address the clinical failings highlighted in this case. The panel had regard to your engagement throughout these regulatory proceedings and this assured the panel that you would comply with a conditions of practice order, and therefore a conditions of practice order would be workable for you.

The panel had regard to the fact that these incidents happened in 2018 and 2020 and that, other than these incidents, you had an unblemished career of around 35 years as a nurse both in [PRIVATE] and in the UK. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. It considered that either of these sanctions would prevent you from addressing the concerns, developing your skills and demonstrating safe practice in order for you to return to unrestricted practice in the future. The panel was satisfied that your misconduct was not fundamentally incompatible with remaining on the register.

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

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

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

1. You must limit your nursing practice to one substantive employer.

2. You must not be the nurse in charge of any shift, ward or unit.

3. You must ensure that you are supervised by working at all times on the same shift as, but not always directly observed by, a registered nurse.

4. You must work with your mentor, supervisor or line manager to develop a Personal Development Plan (PDP) to address the following areas of concern:
    - record keeping
    - escalating the deteriorating patient
    - medicine administration and management
    - clinical observations and assessments
    - dealing with emergencies
    - end of life care
    - collaborating with and communicating in teams to ensure that patient care is effective and adequately prioritised.

5. You must meet with your line manager, mentor or supervisor every month to discuss the standard of your performance and your progress towards achieving the aims set out in your PDP and any other concerns which have arisen.

6. You must forward to the NMC a copy of your PDP within 28 days of starting employment.

7. You must send your case officer a report from your line manager, mentor or supervisor 28 days before any review of this order. This report must comment on your progress towards achieving the aims set out in your PDP and your clinical practice generally, including any concerns which have arisen.

8. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.

b) Giving your case officer your employer's contact details.

9. You must keep us informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

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

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

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

The period of this order is for 12 months.

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

The panel reminded itself that it is open to you to request an early review, should you be able to demonstrate sufficient progress in your development before the expiry of this order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement and attendance at the review hearing,
- An up to date reflective account that provides a broad exploration of the regulatory concerns and the impact of your misconduct on patients, the nursing profession and yourself.
- References and testimonials from any paid or unpaid work, or from those who have a contemporaneous knowledge of your nursing practice.
- Documentary evidence of professional development, including certificates of training addressing the areas of regulatory concern and details of induction training.

This will be confirmed to you in writing.

Interim order

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

interests until the substantive conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Muir. She invited the panel to impose an interim order to cover any appeal period until the substantive order imposed by the panel takes effect.

Mr Weir submitted that you did not oppose the application for an interim order as made by Ms Muir.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to ensure that you cannot practise unrestricted before the substantive conditions of practice order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.