Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
10 – 25 May 2021

Virtual Hearing

Name of registrant:	**Jane Ellen Fallowfield**
NMC PIN:	91I0784E
Part(s) of the register:	Nursing – Sub part 1 RN3: Registered Nurse - Mental Health (17 October 1994)
Area of registered address:	Hull
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, lay member) Pamela Campbell (Registrant member) David Boyd (Lay member)
Legal Assessor:	James Holdsworth
Panel Secretary:	Tara Hoole Holly Girvan (14 May 2021 only)
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Miss Fallowfield:	Not present and unrepresented
Facts proved:	1.1, 1.2, 1.4, 1.5, 1.6, 1.7.1, 1.7.2, 1.8, 1.9, 1.10.1, 1.10.2, 1.10.3, 1.10.4, 1.11, 1.12, 1.13, 1.14, 1.15, 1.16, 1.18.1, 1.18.2, 1.18.3, 1.19, 2.1.1, 2.1.2, 2.2, 2.3, 2.4, 3.1, 3.2, 3.3, 3.4, 4.1, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 5.1.1, 5.1.2, 5.1.3, 5.1.4, 5.1.5, 5.1.6, 6.1, 6.2, 6.3, 6.4, 7.1, 7.2, 7.3.1, 7.3.2, 8.1, 8.2, 8.4, 8.5, 8.6, 9.1, 10.1, 10.2, 10.3, 10.4, 10.5, 11.2, 11.3, 12.1, 12.2, 12.3, 13.1 and 13.2

Facts not proved:	1.3, 1.17, 1.20, 4.2, 8.3, 8.7, 10.6, 10.7, 10.8, 11.1.1 and 11.1.2
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Fallowfield was not in attendance and that the Notice of Hearing letter had been sent to Miss Fallowfield's registered email address on 8 April 2021.

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

The panel took into account that the Notice of Hearing provided details of the allegations, the time and dates and, amongst other things, information about Miss Fallowfield's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. It also contained the link to the virtual hearing.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Fallowfield has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

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

At the outset of the hearing, Mr Edwards made a request that parts of this hearing be held in private on the basis that he would be making reference to the health conditions of several participants involved in this case. The application was made pursuant to Rule 19 of the Rules.

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 that the hearing should be held in public but as matters of health and/or any other matters considered to be private arise that the hearing would then go into private session.

Decision and reasons on proceeding in the absence of Miss Fallowfield

The panel next considered whether it should proceed in the absence of Miss Fallowfield. It had regard to Rule 21 and heard the submissions of Mr Edwards who invited the panel to continue in the absence of Miss Fallowfield. He submitted that Miss Fallowfield had voluntarily absented herself.

Mr Edwards referred the panel to the documentation of several telephone calls between Miss Fallowfield and the NMC Case Officer. In the most recent telephone note dated 21 April 2021 it is recorded that Miss Fallowfield told the NMC Case Officer that she would not be able to attend the hearing [PRIVATE]. She said that she did not want to request a postponement of the hearing [PRIVATE]. She said that she would like the hearing to go ahead without her [PRIVATE].

Mr Edwards submitted that Miss Fallowfield had made it clear that she did not wish to attend and that the hearing should go ahead without her. He submitted that she would not attend if it was postponed to a future date as she has made this clear in her contact with the NMC.

Mr Edwards submitted that there was a public interest in proceeding with the hearing today. The matters concerned came to light in a referral in 2017. Delays have already been incurred due to the pandemic and to postpone the hearing today would likely result in a significant further delay.

Mr Edwards told the panel that several witnesses have been arranged to provide evidence to this panel and it would cause significant inconvenience to them should the hearing be postponed. He submitted that it may also be in Miss Fallowfield's interest that the hearing proceeds and these matters come to a conclusion.

Mr Edwards therefore invited the panel to proceed in Miss Fallowfield's absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Miss Fallowfield. The panel had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Fallowfield;
- Miss Fallowfield has informed the NMC that she has received the Notice of Hearing and has confirmed several times that she does not wish to attend and is content for the hearing to proceed in her absence;
- Four witnesses have been secured to provide live evidence to the panel over the course of the hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2013 and 2016 and further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- There is a strong public interest in the expeditious disposal of the case;

- It may also be in Miss Fallowfield's interest that this matter be concluded expeditiously.

There is some disadvantage to Miss Fallowfield in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her, she has made no formal response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Fallowfield's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Miss Fallowfield. The panel will draw no adverse inference from Miss Fallowfield's absence in its findings of fact.

Details of charge [as amended]

That you a registered nurse, whilst employed by the Humber Trust as the Team Leader of the Recovery and Support Team (RaST)

1. In relation to Patient K:

1.1 On 4 September 2015 did not enter or deduct that two medication amps were given on the medication balance sheet. **Found proved**

1.2 Did not document on the MAR chart and/or the patient communication record sheet that an ampoule was deducted on 6 July 2015. **Found proved**

1.3 Did not document on the MAR chart and/or on the patient communication record sheet that an ampoule was deducted on 21 August 2015. **Found not proved**

1.4 Did not ensure that the patient was seen between 6 November 2013 and 9 March ~~2013~~ **2014**. **Found proved**

1.5 On 25 April 2014 administered a reduced dose of Flupenthixol Decanoate without authority. **Found proved**

1.6 Did not document and/or advise the treating consultant that the care plan was not being adhered to. **Found proved**

1.7 After becoming aware on 23 May ~~2013~~ **2014** that the patient was using Valium did not:

1.7.1 Record and/or inform her GP and/or **Found proved**

1.7.2 Record and or inform her consultant psychiatrist. **Found proved**

1.8 Did not arrange for a CPA review between 2014 and 2015. **Found proved**

1.9 Did not maintain communication and/or visit the patient between 13 June 2014 and 30 April 2015. **Found proved**

1.10 Did not follow the correct procedure when discharging the patient in that you:

1.10.1 Did not undertake a CPA review. **Found proved**

1.10.2 Did not send a discharge letter to the patient. **Found proved**

1.10.3 Did not send a discharge letter to patient's consultant. **Found proved**

1.10.4 Did not send a discharge letter to the patients GP. **Found proved**

1.11 On 30 June 2015 did not document and/or administer the patient's medication which was due. **Found proved**

1.12 On 30 June 2015 did not document any patient entries in the patient's communication notes and/or did not visit the patient. **Found proved**

1.13 On 1 July 2015 did not document any patient entries in the patient's communication notes and/or did not visit the patient. **Found proved**

1.14 On 1 July 2015 signed the medication balance sheet indicating that an ampoule had been removed. **Found proved**

1.15 On 1 July 2015 did not document/and or administer the injection to the patient. **Found proved**

1.16 Were not clear in the patient's documentation what had happened to the ampoule that you signed for on 1 July 2015. **Found proved**

1.17 Were not clear in the patient's documentation what had happened to the medication that you signed for on 21 August 2015. **Found not proved**

1.18 Did not administer and/or document the patients depot injections on the following occasions:

1.18.1 5 August 2015. **Found proved**

1.18.2 19 August 2015. **Found proved**

1.18.3 2 September 2015. **Found proved**

1.19 Were not clear in the patient's documentation what had happened to the medication that you signed for on 6 July 2015. **Found proved**

1.20 Did not ensure that the patient received her depot injection in May 2014. **Found not proved**

2. In or around October 2015:

2.1 Did not keep medication securely in that the following was kept in your work drawer:

2.1.1 used risperdol consta. **Found proved**

2.1.2 unused risperdol consta. **Found proved**

2.2 Did not dispose of used needles correctly in that you kept them in your work drawer. **Found proved**

2.3 Did not store unused needles correctly in that you kept them in your work drawer. **Found proved**

2.4 Did not keep patient notes securely in that you kept patient notes in your work drawer. **Found proved**

3. In relation to Patient A:

3.1 Did not ensure that a care plan was in place. **Found proved**

3.2 Did not ensure that that a risk assessment was in place. **Found proved**

3.3 Did not carry out a follow up visit as required within 7 days from ~~22~~ **17** July 2014, being the date of the patients discharge. **Found proved**

3.4 Between 22 July 2014 and 22 October 2014 did not document and/or visit the patient as required. **Found proved**

4. In relation to Patient B:

4.1 Did not carry out a follow up visit as required within 7 days from the ~~7 April~~ **16 March** 2015 being the date of discharge. **Found proved**

4.2 Did not ensure that the patient's notes were kept in chronological order. **Found not proved**

4.3 Did not put a care plan in place. **Found proved**

4.4 Did not complete care records. **Found proved**

4.5 Did not complete a risk assessment. **Found proved**

4.6 Did not complete a CPA review. **Found proved**

4.7 Did not formulate a risk and relapse plan. **Found proved**

4.8 Between ~~7 April~~ **16 March** 2015 and 30 August 2015 did not document and/or visit the patient as required. **Found proved**

5. In relation to Patient C:

5.1 Between July 2014 and October 2015

5.1.1 Did not document and/or visit the patient. **Found proved**

5.1.2 Did not document and/or carry out any CPA reviews. **Found proved**

5.1.3 Did not document and/or carry out any review meetings. **Found proved**

5.1.4 Did not document and/or carry out any revised care plans. **Found proved**

5.1.5 Did not document and/or carry out an updated risk assessment. **Found proved**

5.1.6 Did not documents and/or carry out an updated relapse plan. **Found proved**

6. In relation to Patient D:

6.1 Did not update the care plan as required. **Found proved**

6.2 Did not document and/or visit the patient after 12 March 2015. **Found proved**

6.3 Did not create/and or update a risk and relapse plan. **Found proved**

6.4 Did not create/and or update a risk assessment. **Found proved**

7. In relation to Patient E:

7.1 Did not ensure that the patient had an up to date risk assessment. **Found proved**

7.2 Did not ensure that a care plan was in place. **Found proved**

7.3 With regards to the CPA did not provide sufficient detail in that you did not;

7.3.1 Provide sufficient content. **Found proved**

7.3.2 Provide any outcome. **Found proved**

8. In relation to Patient F:

8.1 Did not update the risk assessment since creating it on 31 January 2014. **Found proved**

8.2 Did not update a joint services review form since creating it on 4 March 2014. **Found proved**

8.3 Did not assess the patient appropriately between 2014 and September 2015. **Found not proved**

8.4 Did not update the care plan since May 2013. **Found proved**

8.5 Did not update the CPA review. **Found proved**

8.6 Did not complete an AUDIT and Brief Screening. **Found proved**

8.7 Did not make it clear whether reports were submitted to the Ministry of Justice as requested. **Found not proved**

9. In relation to Patient G:

9.1 Between October 2014 and March 2015 did not ensure that there was a second checker. **Found proved**

10. In relation to Patient H:

10.1 Between 20 March 2015 and 10 September 2015 did not keep the patients records in an orderly fashion. **Found proved**

10.2 Did not record and/or conduct a risk assessment. **Found proved**

10.3 Did not record and/or carry out a CPA review. **Found proved**

10.4 Did not record and/or carry out a risk and relapse plan. **Found proved**

10.5 Did not complete a care plan. **Found proved**

10.6 Did not visit the patient as required. **Found not proved**

10.7 On one or more occasions told colleague A that you had visited the patient when you had not. **Found not proved**

10.8 Your actions at charge 10.7 were dishonest in that you sought to create the impression that you had visited the patient when you knew that you had not. **Found not proved**

11. In relation to Patient I:

11.1 Did not sign the following care plans;

11.1.1 December 2015. **Found not proved**

11.1.2 September 2016. **Found not proved**

11.2 When completing the care plan in May 2014 copied the care plan for 2013. **Found proved**

11.3 Did not carry out a proper assessment of the patient when completing the care plan in May 2014. **Found proved**

12. In relation to Patient J:

12.1 Were not clear whether you had completed the risk and relapse plan and/or care plan dated 16 January 2015. **Found proved**

12.2 Did not document and/or communicate with the patient's GP. **Found proved**

12.3 Did not follow up with the patient between March 2015 to October 2015. **Found proved**

13. In relation to Patient L:

13.1 Did not develop and/or complete ~~and~~ care plans. **Found proved**

13.2 Did not carry out any assessments and/~~or~~ any risk assessments. **Found proved**

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

Decision and reasons on application to amend the charge

At the outset of the hearing the panel raised that charges 1.4 and 4.1 may require amendment in respect of the dates.

Mr Edwards made an application to amend charge 1.4 under Rule 28 of the Rules. The proposed amendment was to correct a typographical error in the date specified in the charge. It was submitted by Mr Edwards that the proposed amendment would provide clarity and more accurately reflect the evidence.

Original Charge

1.4 Did not ensure that the patient was seen between 6 November 2013 and 9 March 2013.

Proposed Charge

1.4 Did not ensure that the patient was seen between 6 November 2013 and 9 March ~~2013~~ **2014**.

In respect of charge 4.1 Mr Edwards submitted that he may make a further application in respect of this charge after hearing witness evidence.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Fallowfield and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to correct the typographical error in the date specified.

Decision and reasons on application to admit written statement of Witness 1

The panel heard an application made by Mr Edwards under Rule 31 to allow the written statement of Witness 1 into evidence. Witness 1 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, they were unable to attend today because of their health condition.

In the preparation of this hearing, the NMC had indicated to Miss Fallowfield that Witness 1 would provide live evidence. However, unfortunately Witness 1 is not in a position to attend this hearing to provide evidence. The panel was provided with documentation in respect of Witness 1's health condition.

Miss Fallowfield was informed in a letter dated 27 April 2021, that it was the NMC's intention for Witness 1's evidence to be read at the hearing.

Mr Edwards provided the background to this application. He submitted that Witness 1's evidence was relevant as it speaks to several charges. He submitted that it would be fair in all the circumstances to allow the evidence to be read into the record as it is not the sole and decisive evidence and the matters raised are supported by other witnesses who the panel will hear from in due course. It therefore would not prejudice Miss Fallowfield in any way.

Mr Edwards submitted that Witness 1's reasons for non-attendance are genuine. He therefore invited the panel to allow Witness 1's written statement into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He referred the panel to the cases of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and *NMC v Ogbona* [2010] EWCH 1216.

The panel gave the application in regard to Witness 1 serious consideration. The panel noted that Witness 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and is signed by them.

The panel considered that the evidence provided by Witness 1 is relevant. Further, it is not the sole and decisive evidence in respect of any charge.

The panel accepted that there was a good and cogent reason for Witness 1's non-attendance which was supported by medical evidence.

The panel considered there would be no prejudice to Miss Fallowfield in admitting Witness 1's evidence. She has been sent Witness 1's witness statement and had opportunity to comment on this.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 1, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

Prior to closing the NMC's case, Mr Edwards made an application to amend several of the charges under Rule 28 of the Rules.

In respect of charge 1.7, Mr Edwards reminded the panel of Witness 4's evidence and submitted that there was a typographical error in this charge, the date is correct but the year should be 2014. He submitted that there was no prejudice to Miss Fallowfield in this charge being amended and that it would fully reflect the evidence before the panel.

In respect of charge 3.3, Mr Edwards reminded the panel of Witness 2's evidence in which it was clear that the date of discharge for Patient A was 17 July 2014 rather than 22 July 2014. He submitted that there was no prejudice to Miss Fallowfield in amending this charge as the amendment to the date does not change the substance of the charge other that tidying up a slight error with the dates.

In respect of charge 4.1, Mr Edwards told the panel that it would appear from the evidence that the date of discharge for Patient B was 16 March 2015 rather than 7 April. Again he submitted that this was a typographical error which did not change the substance of the charge and that there was no prejudice to Miss Fallowfield in allowing this amendment.

In respect of charge 4.8, Mr Edwards submitted that it followed that this should also be amended for the same reasons as charge 4.1.

It was submitted by Mr Edwards that the proposed amendments would provide clarity and more accurately reflect the evidence.

Original Charge 1.7

1.7 After becoming aware on 23 May 2013 that the patient was using Valium did not:

Proposed Charge 1.7

1.7 After becoming aware on 23 May ~~2013~~ **2014** that the patient was using Valium did not:

Original Charge 3.3

3.3 Did not carry out a follow up visit as required within 7 days from 22 July 2014, being the date of the patients discharge.

Proposed Charge 3.3

3.3 Did not carry out a follow up visit as required within 7 days from ~~22~~ **17** July 2014, being the date of the patients discharge.

Original Charge 4.1

4.1 Did not carry out a follow up visit as required within 7 days from the 7 April 2015 being the date of discharge.

Proposed Charge 4.1

4.1 Did not carry out a follow up visit as required within 7 days from the ~~7 April~~ **16 March** 2015 being the date of discharge.

Original Charge 4.8

4.8 Between 7 April 2015 and 30 August 2015 did not document and/or visit the patient as required.

Proposed Charge 4.8

4.8 Between ~~7 April~~ **16 March** 2015 and 30 August 2015 did not document and/or visit the patient as required.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel considered each of the proposed amendments separately. It was of the view that the amendments, as applied for, were in the interest of justice. It noted that each of the amendments were to correct typographical errors to dates detailed in the charges and therefore would more accurately reflect the evidence before the panel. The panel was satisfied that the substance of each of the charges remained.

The panel was satisfied that there would be no prejudice to Miss Fallowfield and no injustice would be caused to either party by the proposed amendments being allowed. The panel therefore considered it was appropriate to allow the amendments to charges 1.7, 3.3, 4.1 and 4.8, as applied for, to ensure clarity and accuracy.

The panel noted that there was a typographical error in charge 13.1. It decided, of its own volition, to amend this to remove the additional ‘and’.

Original charge

13.1 Did not develop and/or complete and care plans.

Proposed charge

13.1 Did not develop and/or complete ~~and~~ care plans.

The panel was satisfied that there would be no prejudice to Miss Fallowfield in removing the additional ‘and’ and no injustice would be caused to either party by the proposed amendments being allowed.

Decision and reasons on recalling an NMC witness

Prior to the close of the NMC case the panel heard an application to recall Witness 3 to clarify certain issues which had arisen in subsequent witness evidence.

The panel considered it both fair and relevant to recall Witness 3 to provide the details needed to clarify the issues. It therefore accepted the application and Witness 3 was recalled to provide evidence on several distinct matters.

Background

The NMC received a referral from Miss Fallowfield's employer in March 2017. The charges arose whilst Miss Fallowfield was employed as a Band 7 Mental Health Nurse by Humber NHS Foundation Trust (the Trust). Miss Fallowfield had worked for the Trust since she registered as a nurse in 1994 until her dismissal in 2017.

The charges relate to Miss Fallowfield's practice between 2013 and 2015. Miss Fallowfield was working as an experienced Community Psychiatric Nurse (CPN) and Team Leader of the Recovery and Support Team (RaST). Her role included the delivery of care to patients with severe and enduring mental health problems living in the community (at the time carrying a caseload of 14 patients), supervision of, and being a role model for, more junior staff. Concerns were raised in September 2015 following a medication error. Upon investigation major concerns were identified and the review of Miss Fallowfield's records and care was widened.

The concerns identified in this case relate to Miss Fallowfield failing to maintain adequate records in relation to 12 patients allocated to her, including allegations that she failed to visit patients, produce care plans, risk assessments and relapse and risk management plans. Further concerns were identified relating to Patient K being inappropriately discharged and a failure to administer depot injections to Patient K.

Throughout this determination the terms CPN and Care Co-ordinator are used interchangeably as Miss Fallowfield's role as team leader means that her responsibilities in relation to patient care are the same, regardless of whether she is CPN or acting formally in the Care Co-ordinator role.

Witness Assessment

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

- Witness 2: Band 8C Assistant Director of Nursing at the time of the investigation;
- Witness 3: Operational Service Manager for Hull Adult Mental Health Community Teams at the relevant time;
- Colleague A: Care Officer for Hull East Community Mental Health Team at the relevant time;
- Witness 4: Non-medical Prescribing Lead and Medicine Optimisation Lead Nurse at Humberside NHS Foundation Trust at the relevant time.

The panel also accepted into evidence the written statement of Witness 1.

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.

The panel considered the evidence of the witnesses and made the following conclusions:

Witness 2: Witness 2 conducted the investigation into Miss Fallowfield's practice. The panel was satisfied that this was a thorough investigation. The panel considered that

Witness 2 was an articulate and confident witness who had been genuinely shocked and upset by some of the findings in her investigation. Witness 2 was fair to Miss Fallowfield in her evidence, she pointed out good as well as poor practice. She did her best to assist the panel and conceded when she did not know or could not recall the answer to a question. Overall the panel considered the evidence of Witness 2 to be credible and reliable.

Witness 3: The panel considered Witness 3 to have been a straightforward and competent witness. She had only been appointed as Miss Fallowfield's line manager three weeks prior to concerns being raised in respect of Miss Fallowfield's practice. She was able to clarify processes and procedures in the community team at the time, in particular with regards to the team's use of the computer software 'Lorenzo'. She did her best to assist the panel and conceded when she did not know or could not recall something. Overall the panel considered the evidence of Witness 3 to be credible and reliable.

Witness 4: The panel considered Witness 4 gave competent and clear evidence in respect of Patient H and did his best to assist the panel. The panel noted that Witness 4 was somewhat guarded in his responses to the panel's questions regarding whether there was any bullying behaviour in the team. On occasion Witness 4 deviated from the subject in question. However, he had good recall and overall the panel considered the evidence of Witness 4 to be credible and generally reliable.

Witness 5: The panel considered that Witness 5's evidence was generally consistent with her written evidence and she did her best to assist the panel. However, she appeared to become confused in respect of some aspects of her evidence, was vague regarding certain issues and on occasion was contradictory in the evidence she gave to the panel. She provided a lot of personal opinion within her evidence which was not backed up by policies or procedure documentation. The panel considered the evidence of Witness 5 to be generally credible although not always reliable in certain aspects.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Edwards. It also took into account the 'Mitigation Statement' dated 9 January 2017 from Miss Fallowfield. The panel accepted the advice of the legal assessor who drew its attention to the case of *Ivey v Genting Casinos* [2017] UKSC 67 when determining dishonesty charges.

The panel has drawn no adverse inference from the non-attendance of Miss Fallowfield.

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

Charge 1.1

1. In relation to Patient K:

    1.1 On 4 September 2015 did not enter or deduct that two medication amps were given on the medication balance sheet.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence, a letter from Patient K's Consultant Psychiatrist dated 24 June 2014, the 'Guidance on delivery of the Care Programme Approach' policy document, the Band 7

Team Leader job description, Witness 1's written witness statement, the Depot Injections Prescription Form for Patient K and the Medication Balance Sheet for Patient K.

Prior to making any findings in respect of the charges relating to Patient K, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient K.

The panel had regard to Witness 4's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient K. She told the panel that Miss Fallowfield was allocated to Patient K as their CPN on 26 March 2014.

Witness 2 provided further evidence to the panel that Miss Fallowfield was the allocated CPN in the form of a letter from Patient K's Consultant Psychiatrist, dated 24 June 2014, which was copied to Miss Fallowfield, CPN.

The panel was therefore satisfied that Miss Fallowfield was the allocated Care Co-ordinator for Patient K at the relevant time.

The panel had regard to the 'Guidance on delivery of the Care Programme Approach' which clearly outlines the role of Care Co-ordinator as:

'The Identified Care Co-ordinator will deliver the role within the following principles of practice.

- *work **in partnership** with people who have complex mental health and social care needs, and those supporting them;*
- *strives to empower people using services to have choices and make decisions to determine their wellbeing and recovery;*
- *ensures comprehensive assessment (including risk assessments) occurs and organises regular reviews of care to take place*
- *co-ordinates a person's journey through all parts of the health and social care system;*

- *enables each person to have a personalised care plan based on his/her needs, preferences and choices;*
- *ensures that the person receives the least restrictive care in the setting most appropriate for that person;*
- *supports the person to attain wellbeing and recovery;*
- *ensures that the needs of carers/families are addressed;*
- *brokers partnerships with health and social care agencies and networks which can respond to, and help to meet the needs of the person who is experiencing mental health problems.'*

In addition the panel had regard to the job description for Ms Fallowfield's role as a Band 7 Team Leader which states that she would have had responsibilities for completion of paperwork both for her own cases and those of her team.

The panel was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield at the time including the obligation to maintain clear and up to date records of patient's in her care.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient K the panel moved on to consider charge 1.1.

The panel noted Witness 1's witness statement which stated:

> *'The DATIX states "[w]hen reviewing the Medication balance Sheet, Mar chart, it became apparent that the 2 medication amps for depot given on the 4/9/2015 had not been entered or deducted from the Medication Balance Sheet. Therefore there are no missing ampoules. On examining the Medication Balance Sheet, an ampoule was deducted on 6/7/2015 (sequentially it appears it should have been 6/8/2015) and 21/8/2015, however this was not documented on MAR or the patient communication record."'*

In her oral evidence Witness 4 took the panel through the Medication Balance Sheet for Patient K. At the bottom of the sheet there is a note which reads '*Balance incorrect – prior to last 2 being taken to accommodate increased dose*'.

The panel had regard to the Depot Injections Prescription Form for Patient K which contains an entry dated 4 September 2015 and is signed by Miss Fallowfield as having been administered to Patient K.

The panel noted there is no entry on the Medication Balance Sheet for Patient K which relates to 4 September 2015. The entries go from 21 August 2015 to 18 September 2015.

The panel concluded that the evidence before it suggests that Miss Fallowfield administered the medication to Patient K on 4 September 2015 but did not update the Medication Balance Sheet.

The panel consequently determined that, on the balance of probability, in relation to Patient K, on 4 September 2015 Miss Fallowfield did not enter or deduct that two medication amps were given on the Medication Balance Sheet.

The panel therefore found this charge proved.

Charge 1.2

1. In relation to Patient K:

    1.2 Did not document on the MAR chart and/or the patient communication record sheet that an ampoule was deducted on 6 July 2015.

This charge is found proved.

In reaching this decision, the panel took into account the Depot Injections Prescription Form for Patient K, Patient K's care notes and the Medication Balance Sheet for Patient K along with its findings at charge 1.1.

When looking at this charge the panel concluded that this was referring to the fact that an ampoule was deducted on 6 July but there was no record of what was done with the ampoule. The panel considered that Miss Fallowfield should have documented what had happened with the ampoule.

The panel had regard to the Medication Balance Sheet for Patient K in which it is recorded that Miss Fallowfield deducted an ampoule on 6 July 2015. The panel then considered the Depot Injections Prescription Form for Patient K (MAR chart) in which there is no entry on 6 July 2015. Finally the panel had regard to Patient K's care notes in which there is no entry for 6 July 2015. The entries go from 16 June 2015 to 9 July 2015.

The panel considered that although Miss Fallowfield recorded an ampoule as deducted on 6 July 2015 on Patient K's Medication Balance Sheet there is no documentation relating to this ampoule on Patient K's Depot Injections Prescription Form (MAR chart) in respect of the administration (or not) of this ampoule.

The panel determined that Miss Fallowfield did not document on Patient K's MAR chart and/or the patient communication record sheet that an ampoule was deducted on 6 July 2015. The panel therefore found this charge proved.

Charge 1.3

1. In relation to Patient K:

    1.3 Did not document on the MAR chart and/or on the patient communication record sheet that an ampoule was deducted on 21 August 2015.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence, Patient K's Care Notes (communication record sheet), the Depot Injections Prescription Form (MAR chart) for Patient K and the Medication Balance Sheet for Patient K.

The panel had regard to the Medication Balance Sheet for Patient K. The panel noted that the signature for the entry 21 August 2015 is initialled 'JEF' whereas all the entries signed by Miss Fallowfield are signed 'J Fallowfield'.

Witness 4 told the panel in her oral evidence that she had presumed that the initials JEF related to Miss Fallowfield but on reflection she could not be sure.

The panel noted that there was no entry on the MAR chart or communication record sheet to record what happened to an ampoule taken out on 21 August 2015.

The panel had not come across a similar entry in all of the documentation before it where Miss Fallowfield has used the initials JEF as her signature.

The panel was not content that the signature on 21 August 2015 on the Medication Balance Sheet for Patient K was that of Miss Fallowfield, particularly in light of Witness 4's oral evidence and her uncertainty.

The panel was not satisfied on the basis of the evidence before it that it could conclude on the balance of probability that Miss Fallowfield did not document on the MAR chart and/or on the patient communication record sheet that an ampoule was deducted on 21 August 2015.

This charge is therefore found not proved.

Charge 1.4

1. In relation to Patient K:

    1.4 Did not ensure that the patient was seen between 6 November 2013 and 9 March ~~2013~~ **2014**.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence and Patient K's patient care notes. .

Witness 4 told the panel that upon reviewing Patient K's care notes it was clear that there had been no contact with Patient K from 5 November 2013 until Patient K called the team seeking support on 10 March 2014.

The panel had regard to Patient K's care notes which show an entry on 5 November 2013 and no further entries until 10 March 2014 when there is a record of Patient K telephoning the team. The patient notes do not record any attempts made to contact Patient K between these two dates or an explanation as to the gap in the care provided. The panel noted that as Patient K's allocated CPN, Miss Fallowfield would have had a duty to ensure that Patient K was receiving appropriate care.

The panel determined that Miss Fallowfield did not ensure Patient K was seen between 6 November 2013 and 9 March 2014.

The panel therefore found this charge proved.

Charge 1.5

1. In relation to Patient K:

    1.5 On 25 April 2014 administered a reduced dose of Flupenthixol Decanoate without authority.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence, Patient K's Care Notes and the Depot Injections Prescription Form (MAR chart) for Patient K.

In Patient K's care notes there is an entry dated 25 April 2014 14:00H which states '*Seen at home this morning at 10 am, Patient K reports to be feeling better but states that she only would be prepared to accept 10mgs of her medication today. Explained about therapeutic doses and Patient K fully understood this. With consent administered 10mgs for Depixol [Flupenthixol Decanoate] to the right upper outer muscle – site clear, no concerns'* and is signed by Miss Fallowfield.

In addition the Depot Injections Prescription Form for Patient K shows an entry on 25 April 2014 for 10mgs Flupenthixol Decanoate administered to Patient K's right side and is signed by Miss Fallowfield. The panel noted that the prescription (dated 21 March 2014) clearly states the dose to be 20mg administered every two weeks.

The panel therefore considered it is clear that Miss Fallowfield administered a reduced dose of Flupenthixol Decanoate on 25 April 2014.

On questioning by the panel during her oral evidence Witness 4 accepted that 10mgs would have been a sub-therapeutic dose of Flupenthixol Decanoate.

The panel had been clearly drawn to the following entry in Patient K's notes, dated 1 May 2014, which shows another CPN seeking authority from the prescribing doctor before agreeing to administer a reduced dose of 10mgs to Patient K. The panel considered this to be a clear indication that only the prescriber has the authority to change the prescribed dose. Miss Fallowfield did not appear to have consulted the prescribing doctor in respect of the administration of a reduced dose. A reduced dose should only have been given after prior consultation with the prescriber as any change could have had an adverse effect on the patient. The panel noted that Miss Fallowfield was not a nurse prescriber.

On this basis the panel concluded that on the balance of probability, Miss Fallowfield administered a reduced dose of Flupenthixol Decanoate to Patient K on 25 April 2014, without authority.

The panel therefore found this charge proved.

Charge 1.6

1. In relation to Patient K:

    1.6 Did not document and/or advise the treating consultant that the care plan was not being adhered to.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence, Patient K's Care Notes and the Depot Injections Prescription Form (MAR chart) for Patient K along with its findings at charge 1.5.

The panel considered that there was nothing in Patient K's notes which indicated that Miss Fallowfield had advised the treating consultant that the care plan was not being adhered to in respect of Patient K not receiving the prescribed dose of 20mgs depot injection.

The panel considered there would have been a duty on Miss Fallowfield as Patient K's CPN to communicate to the treating consultant that a reduced dose of the depot injection had been administered.

The panel therefore found this charge proved.

Charge 1.7.1 and 1.7.2

1. In relation to Patient K:

    1.7 After becoming aware on 23 May ~~2013~~ **2014** that the patient was using Valium did not:

        1.7.1 Record and/or inform her GP and/or

        1.7.2 Record and or inform her consultant psychiatrist.

The panel decided to consider charges 1.7.1 and 1.7.2 together.

These charges are found proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence as well as Patient K's care notes.

The panel had regard to Patient K's care notes dated 23 May 2014 in which Miss Fallowfield clearly references that Patient K was using Valium.

In her evidence Witness 4 confirmed that there was reference in Patient K's notes that she was using Valium. Witness 4 told the panel that she would have expected Miss Fallowfield to have spoken with Patient K's GP to make them aware of the use of Valium and determine if this was prescribed as well as informing Patient K's consultant psychiatrist. Witness 4 told the panel that even if Miss Fallowfield had verbally told the GP and consultant psychiatrist it should also have been clearly documented in the patient notes. In her oral evidence Witness 4 outlined the possible consequences of these failings.

The panel was content that on 23 May 2014 Miss Fallowfield was aware of Patient K's use of Valium. The panel considered that there was no evidence in Patient K's notes that Miss Fallowfield informed Patient K's GP or consultant psychiatrist.

The panel therefore determined that, on the balance of probability, charge 1.7.1 and charge 1.7.2 were found proved.

Charge 1.8

1. In relation to Patient K:

    1.8 Did not arrange for a CPA review between 2014 and 2015.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's oral and written evidence, the 'Guidance on delivery of the Care Programme Approach' policy document and Patient K's care notes.

The panel had sight of the 'Guidance on delivery of the Care Programme Approach' policy document which sets out when CPA's should be reviewed. This document confirms that a

Care Co-ordinator should organise on-going reviews, formal multi-disciplinary, multi-agency review at least twice a year (should be need dependant) and that it will be the case manager's responsibility to ensure service users are seen on a six monthly basis. The panel therefore concluded that, as Patient K's allocated Care-Coordinator, Miss Fallowfield had an obligation to arrange CPA reviews at least once every six months.

Witness 2 confirmed in her evidence that she would expect CPA reviews to be conducted at least every six months for patients under the Care Programme Approach.

The panel had regard to Patient K's care notes in which there are no records of CPA reviews occurring between 2014 and 2015. This is in spite of significant changes in circumstances for Patient K during this time.

The panel determined that, on the balance of probability, Miss Fallowfield did not arrange for a CPA review for Patient K between 2014 and 2015.

The panel therefore found this charge proved.

Charge 1.9

1. In relation to Patient K:

    1.9 Did not maintain communication and/or visit the patient between 13 June 2014 and 30 April 2015.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence, the Lorenzo spreadsheet containing records of Miss Fallowfield's contact with patients and Patient K's care notes.

In her evidence, Witness 4 told the panel that there was no record of any attempt by Miss Fallowfield to contact Patient K for a period of 10 months. Witness 4 told the panel that Miss Fallowfield should have raised concerns about Patient K's disengaging with treatment.

The panel had regard to Patient K's care notes. The notes record an attempted telephone call to Patient K on 13 June 2014 by Miss Fallowfield. The next entry in the notes is dated 30 April 2015 and, whilst not signed, states '*Patient K has not been in touch with the team since refusing her depot injection last June. She did not attend her out patients appointments either, therefore discharge from service'*. The panel noted there were no attempts at contact with Patient K between these two dates.

The panel noted that there were no entries in the Lorenzo spreadsheet (at the time Lorenzo was an electronic diary system used to record contact with patients) to indicate that there was any contact from Miss Fallowfield with Patient K in this time period.

The panel concluded that, on the balance of probability, Miss Fallowfield did not maintain communication or visit Patient K between 13 June 2014 and 30 April 2015.

The panel therefore found this charge proved.

Charges 1.10.1, 1.10.2, 1.10.3 and 1.10.4

1. In relation to Patient K:

    1.10 Did not follow the correct procedure when discharging the patient in that you:

        1.10.1 Did not undertake a CPA review.

1.10.2 Did not send a discharge letter to the patient.

1.10.3 Did not send a discharge letter to patient's consultant.

1.10.4 Did not send a discharge letter to the patient's GP.

The panel decided to consider charges 1.10.1, 1.10.2, 1.10.3 and 1.10.4 together.

These charges are all found proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence, the 'Guidance on delivery of the Care Programme Approach' policy document and Patient K's care notes.

In the 'Guidance on delivery of the Care Programme Approach' policy document it states:

'DISCHARGE FROM MENTAL HEALTH SERVICES

Where it has been agreed at review that discharge from secondary care services is appropriate then this decision should be recorded on the appropriate documentation. The only criterion for discharge is that the Service User no longer needs support from any part of the Mental Health Services.

Where the Service User requests that CPA be terminated against the advice of the MH Care Co-ordinator and/or multi-disciplinary team, then every effort must be made to develop/present a care plan that is acceptable to that individual. This could mean delivering only part of the original plan or making substantial modifications.

Where compromise cannot be reached then support should be offered to the Service User and/or any carer. The Service User and/or their carers should be given full details of how to contact the Mental Health Services for future reference.

Withdrawal of a particular service or intervention should only take place with the agreement of the multi-disciplinary team following full discussion with those persons/agencies involved in the Service User's care. Unilateral withdrawal of services or discharge from caseloads will be avoided at all times.'

The panel noted that the formal procedure is for a letter to go to the patient, the patient's consultant and the patient's GP. The panel noted there was no record of any such letters within Patient K's notes.

In her oral evidence to the panel Witness 4 confirmed the correct procedure which should be followed in discharging a patient from RaST. She told the panel that in the event of discharging a patient a CPA review should be completed with the multi-disciplinary team involved in the patient's care. She told the panel that there was no record of this CPA taking place prior to Patient K's discharge. She further told the panel that upon formal discharge from the service that the procedure would be for Miss Fallowfield to send a discharge letter to Patient K (charge 1.10.2), to the patient's consultant (charge 1.10.3) and to the patient's GP (charge 1.10.4). She told the panel that without these formal discharge letters the consultant and GP would presume that the treatment was being carried out and that there were no concerns regarding Patient K.

The panel considered that, on the balance of probability, given the lack of any documentation relating to Patient K's discharge, Miss Fallowfield did not follow the correct procedure when discharging Patient K in that she did not undertake a CPA review (charge 1.10.1), she did not send a discharge letter to Patient K (charge 1.10.2), she did not send a discharge letter to Patient K's consultant (1.10.3) and she did not send a discharge letter to Patient K's GP (charge 1.10.4).

The panel therefore found charges 1.10.1, 1.10.2, 1.10.3 and 1.10.4 proved.

Charge 1.11

1. In relation to Patient K:

    1.11 On 30 June 2015 did not document and/or administer the patient's medication which was due.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's oral and written evidence, Patient K's Depot Injections Prescription Form, the Medication Balance Sheet for Patient K, Patient K's care notes and the Lorenzo spreadsheet detailing Miss Fallowfield's contact with patients.

In her evidence to the panel Witness 4 confirmed that Patient K should have had a depot injection on 30 June 2015 in line with her prescription.

The panel had regard to Patient K's Depot Injections Prescription Form which detailed that Patient K was to be administered a 20mg depot injection of Flupenthixol Decanoate every two weeks.

Patient K's care notes indicate that Miss Fallowfield administered a depot injection on 16 June 2015. It also detailed the date of the next depot injection as 30 June 2015. The panel considered that this indicated Miss Fallowfield was aware that Patient K was due her next depot injection on 30 June 2015.

Subsequent examination of Patient K's care notes, the depot injection prescription form and the Medication Balance Sheet do not show any entries of a depot injection being administered on 30 June 2015. The depot injection prescription form recorded that Miss Fallowfield administered Patient K's depot injection on 16 June 2015. The next entry in the form is dated 7 July 2015 where the ward based nurse gave the injection.

The panel had regard to the Lorenzo spreadsheet which detailed a face to face appointment on 30 June with Patient K. Whilst there is an entry on the Lorenzo system there is nothing in Patient K's care notes to show that this appointment actually took place or that the depot injection which was due was administered on 30 June 2015.

The panel had regard to the Medication Balance Sheet, whilst there is no entry dated 30 June 2015 there is an entry by Miss Fallowfield dated 1 July 2015. Witness 4 told the panel that this may indicate that Miss Fallowfield had given Patient K a depot injection at around 1 July 2015.

The panel noted the entry in Patient K's care notes dated 9 July 2015 which detailed Patient K attended an out-patient appointment at which she was given her prescribed depot injection on agreement from the doctor as the notes indicated that she had not received this since 16 June 2015. In respect of this the panel heard evidence from Witness 4 that the confusion over whether the medication was given or not may have led to Patient K receiving an extra depot injection.

The panel concluded that on 30 June 2015 Miss Fallowfield did not document and/or administer Patient K's depot injection medication which was due.

The panel therefore found this charge proved.

Charge 1.12

1. In relation to Patient K:

    1.12 On 30 June 2015 did not document any patient entries in the patient's communication notes and/or did not visit the patient.

This charge is found proved.

In reaching this decision, the panel took into account the evidence reviewed at charge 1.11 above and its findings in respect of that charge.

The panel noted that there were no entries in Patient K's care notes for 30 June 2015. Whilst there was an administrative entry in the Lorenzo spreadsheet for this date, this is a diary only based system, correct procedure would have been to document any contact within the patient communication notes. The panel concluded that Miss Fallowfield did not document any patient entries or did not visit Patient K on 30 June 2015.

The panel therefore found this charge proved.

Charge 1.13

1. In relation to Patient K:

    1.13 On 1 July 2015 did not document any patient entries in the patient's communication notes and/or did not visit the patient.

This charge is found proved.

In reaching this decision, the panel took into account the evidence reviewed at charge 1.11 above and its findings in respect of that charge.

The panel noted that Miss Fallowfield had signed Patient K's Medication Balance Sheet on 1 July 2015. However, there is no record in Patient K's care notes or in Patient K's Depot Injections Prescription Form for 1 July 2015.

On the balance of probability, the panel concluded that Miss Fallowfield did not document any patient entries in Patient K's care notes and/or did not visit Patient K on 1 July 2015.

The panel therefore found this charge proved.

Charge 1.14

1. In relation to Patient K:

    1.14 On 1 July 2015 signed the medication balance sheet indicating that an ampoule had been removed.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's evidence and Patient K's Medication Balance Sheet.

The panel noted that Miss Fallowfield had signed Patient K's Medication Balance Sheet on 1 July indicating that she had removed an ampoule.

Witness 4 confirmed this in her evidence to the panel.

The panel therefore found this charge proved on a factual basis.

Charge 1.15

1. In relation to Patient K:

1.15 On 1 July 2015 did not document/and or administer the injection to the patient.

This charge is found proved.

In reaching this decision, the panel took into account the evidence reviewed at charge 1.11, 1.13 and 1.14 above and its findings in respect of those charges.

The panel noted that there was no entry in Patient K's care notes or in the Depot Injection Prescription Form to record that the depot medication removed, as detailed at charge 1.14, was administered to Patient K.

The panel therefore concluded that on 1 July 2015 Miss Fallowfield did not document and/or administer the depot injection to Patient K.

The panel therefore found this charge proved.

Charge 1.16

1. In relation to Patient K:

1.16 Were not clear in the patient's documentation what had happened to the ampoule that you signed for on 1 July 2015.

This charge is found proved.

In reaching this decision, the panel took into account the evidence reviewed at charge 1.11, 1.13, 1.14 and 1.15 above and its findings in respect of those charges.

Given its previous findings regarding the lack of any entry in Patient K's documentation relating to the ampoule recorded as removed on the Medication Balance Sheet the panel concluded that there was a lack of clarity in respect of what happened to the ampoule that Miss Fallowfield signed for on 1 July 2015.

The panel therefore found this charge proved.

Charge 1.17

1. In relation to Patient K:

    1.17 Were not clear in the patient's documentation what had happened to the medication that you signed for on 21 August 2015.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 4's evidence and Patient K's Medication Balance Sheet.

As detailed at charge 1.3 above the panel was not content that the signature on 21 August 2015 on the Medication Balance Sheet for Patient K was that of Miss Fallowfield, particularly in light of Witness 4's oral evidence and her uncertainty.

Given the panels finding that charge 1.3 was not proved on basis of there not being sufficient evidence to conclude that this was Miss Fallowfield's signature this charge falls away.

The panel therefore found this charge not proved.

Charge 1.18.1, 1.18.2 and 1.18.3

1. In relation to Patient K:

    1.18 Did not administer and/or document the patient's depot injections on the following occasions:

        1.18.1 5 August 2015.
        1.18.2 19 August 2015.
        1.18.3 2 September 2015.

The panel considered charges 1.18.1, 1.18.2 and 1.18.3 together.

These charges are found proved.

In reaching this decision, the panel took into account Witness 4's evidence, Patient K's Depot Injections Prescription Form, the Medication Balance Sheet for Patient K and Patient K's care notes.

In her evidence to the panel Witness 4 confirmed that Patient K was due depot injections on 5 August 2015, 19 August 2015 and 2 September 2015.

The panel had regard to Patient K's Depot Injection Prescription Form which indicated that the depot injections should be administered every two weeks. The last entry on this form is dated 22 July 2015. The next prescription chart commences on 4 September 2015.

The panel had regard to Patient K's care notes. There is no indication within these of any administration or documentation that the depot injections were given on or around these dates or any explanation as to why these were not given. The notes go from an entry dated 22 July 2015 in which Miss Fallowfield records administering the depot injection to

an entry dated 3 September 2015. There is also no entry corresponding to these dates in the Medication Balance Sheet.

The panel determined that Miss Fallowfield did not administer or did not document Patient K's depot injections on 5 August 2015, 19 August 2015 and 2 September 2015.

The panel therefore found charges 1.18.1, 1.18.2 and 1.18.3 proved.

Charge 1.19

1. In relation to Patient K:

    1.19 Were not clear in the patient's documentation what had happened to the medication that you signed for on 6 July 2015.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's evidence, Patient K's Depot Injections Prescription Form, the Medication Balance Sheet for Patient K and Patient K's care notes.

In her evidence Witness 4 confirmed that she could not be clear what had happened to the ampoule of medication that Miss Fallowfield signed out on the Medication Balance Sheet dated 6 July 2015.

The panel had regard to the Medication Balance Sheet and noted Miss Fallowfield had signed for the removal of medication on 6 July 2015.

On review of Patient K's care notes and Depot Injection Prescription form the panel could not see a record of medication being administered on 6 July 2015 to Patient K or any

indication of what had been done with the medication signed for on the Medication Balance Sheet.

The panel determined that Miss Fallowfield was not clear in Patient K's documentation of what had happened to the medication that she signed for on 6 July 2015.

The panel therefore found this charge proved.

Charge 1.20

1. In relation to Patient K:

    1.20 Did not ensure that the patient received her depot injection in May 2014.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 4's evidence, Patient K's Depot Injections Prescription Form, the Medication Balance Sheet for Patient K and Patient K's care notes.

The panel had regard to Patient K's Depot Injection Prescription Form for the relevant time period. It noted that there were three entries in May 2014. On 3 May 2014 a reduced dose of medication was administered. On 9 May 2014 it appears that the depot injection was administered to Patient K and on 23 May 2014 it appears that Patient K refused the depot injection. Witness 4 confirmed to the panel in her evidence that the variant code against the entry of 23 May 2014 indicated a patient refusing their medication. The panel noted that there is no evidence that Patient K was on a community treatment order and as such Miss Fallowfield had to respect Patient K's right to refuse the medication.

Given these entries the panel concluded that Miss Fallowfield had administered and offered to administer Patient K's depot injection on 3, 9 and 23 May 2014.

The panel therefore found this charge not proved.

Charge 2.1.1 and 2.1.2

2. In or around October 2015:

2.1 Did not keep medication securely in that the following was kept in your work drawer:

2.1.1 used risperdol consta.
2.1.2 unused risperdol consta.

The panel considered charged 2.1.1 and 2.1.2 together.

These charges were both found proved.

In reaching this decision, the panel took into account Witness 4's evidence, the Waste Management Policy and the Safe and Secure Handling of Medications Procedure for the Trust at the time.

In October 2015, as part of the investigation into Miss Fallowfield's practice, her desk drawer was searched. In an unlocked drawer an amount of used and unused risperdol consta medication and needles were found along with other confidential items including patient notes, staff notes and other documentation.

Witness 4 in her oral evidence confirmed the procedure for dealing with the used and unused risperdol consta (an injection) contained within the drawer, in particular she

confirmed the procedure for disposing of used needles. She told the panel that medication, whether used or unused, should not have been stored in a desk drawer and explained the reasons behind this. Any unused risperdol consta medication should have been placed back into the fridge where such medication is stored at the correct temperature and therefore can be used in the future.

The panel had regard to the Waste Management Policy which gives clear guidance on the disposal of sharps. Used sharps, including needles should be discarded in the appropriate Sharps Disposal Container and never in any other receptacle. The panel was therefore satisfied that Miss Fallowfield should have disposed of the used risperdol consta including the used needle in a sharps bin and not by keeping it in her desk drawer and as such determined that she did not keep the medication securely (charge 2.1.1).

The panel had regard to the Safe and Secure Handling of Medications Procedure for the Trust at the time which states ‘All medicines, disinfectants and reagents must be stored in locked cupboards, trolleys or other secure cabinets – reserved solely for medicinal products.’ The panel was of the view that keeping medication in a desk drawer was not the correct procedure for storing unused risperdol consta and as such determined that Miss Fallowfield did not keep the medication securely (charge 2.1.2).

Having regard to the evidence as outlined the panel determined that the medication was not kept securely or appropriately in clear breach of the policies outlined.

The panel therefore found charge 2.1.1 and charge 2.1.2 proved.

Charge 2.2

2. In or around October 2015:

2.2 Did not dispose of used needles correctly in that you kept them in your work drawer.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's and Witness 4's evidence and the Waste Management Policy along with its findings at charge 2.1.1 and 2.1.2 above.

The panel considered that the Waste Management Policy was clear that used needles should be disposed of in the appropriate sharps bin.

In their oral evidence Witness 4 and Witness 3 both confirmed to the panel the correct procedure to dispose of used needles and explained the potential risks of needles not being disposed of correctly. Each confirmed that risperdol consta was a medication given by injection with a needle.

The panel determined that in October 2015, Miss Fallowfield did not dispose of used needles correctly in that she kept them in her work drawer rather than disposing of them in the appropriate manner.

The panel therefore found this charge proved.

Charge 2.3

2. In or around October 2015:

2.3 Did not store unused needles correctly in that you kept them in your work drawer.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's evidence and the Safe and Secure Handling of Medications Procedure for the Trust at the time along with its findings at charge 2.1.1 and 2.1.2 above.

Witness 4 told the panel the correct procedure for storing unused needles which accorded with the Safe and Secure Handling of Medications Procedure for the Trust at the time.

The panel was satisfied on the basis of its findings above that Miss Fallowfield did not store the unused risperdol consta needles correctly by keeping them in her work drawer. The panel considered that this medication should have been kept in an appropriate medication cabinet or similar as described in the Safe and Secure Handling of Medications Procedure.

The panel therefore found this charge proved.

Charge 2.4

2. In or around October 2015:

2.4 Did not keep patient notes securely in that you kept patient notes in your work drawer.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2, Witness 3 and Witness 4's evidence along with the minutes of a meeting with Miss Fallowfield dated 14 September 2016.

The panel heard evidence from Witness 2, Witness 3 and Witness 4 that the procedure at the unit at the time was for all patient notes to be kept securely in a locked cabinet overnight within a locked room, with clear procedures, including the use of booking out sheets for any removal. The panel heard that patient notes should not be kept in a desk drawer as this was not secure and also would not be accessible to others in the event of the patient notes being required.

The panel had regard to the minutes of a meeting with Miss Fallowfield dated 14 September 2016 regarding the investigation into her practice. When asked about the patient notes found in her desk drawer Miss Fallowfield admitted to having put the patient notes in her desk. [PRIVATE].

Having heard this evidence the panel determined that, on the balance of probability, Miss Fallowfield did not keep patient notes securely in that she kept patient notes in her work drawer.

The panel therefore found this charge proved.

Charge 3.1

3. In relation to Patient A:

3.1 Did not ensure that a care plan was in place.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's oral and written evidence, the Interim Discharge Summary for Patient A dated 17 July 2014, the 'Guidance on delivery of the Care Programme Approach' and Patient A's care notes.

Prior to making any findings in respect of the charges relating to Patient A, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient A.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient A. She told the panel that Miss Fallowfield was allocated to Patient A as their CPN on 22 July 2014.

Witness 2 provided further evidence to the panel that Miss Fallowfield was the allocated CPN in the form of an Interim Discharge Summary for Patient A, dated 17 July 2014, which lists Miss Fallowfield as the Care Co-ordinator.

The panel was therefore satisfied that Miss Fallowfield was the allocated Care Co-ordinator for Patient A at the relevant time.

The panel had regard to the 'Guidance on delivery of the Care Programme Approach' which clearly outlines the role of Care Co-ordinator as detailed in charge 1.1 above. From this it is clear that a care plan should have been in place for Patient A.

Witness 2, in her oral evidence, told the panel that Patient A was a high risk patient due to their medical history.

The panel had sight of the 'Guidance on delivery of the Care Programme Approach' policy document which sets out when CPA's should be reviewed. This document confirms that a Care Co-ordinator should organise on-going reviews, formal multi-disciplinary, multi-agency review at least twice a year (need dependant) and that it was the case manager's responsibility to ensure service users are seen on a six monthly basis. The panel therefore concluded that, as Patient A's allocated Care-Coordinator, Miss Fallowfield had an obligation to arrange CPA reviews at least once every six months.

Witness 2 confirmed in her evidence that she would expect CPA reviews to be conducted at least every six months for patients under the Care Programme Approach.

The panel had regard to Patient A's care notes. There are no care plans contained within these notes and no record of CPA reviews occurring despite the requirement to conduct these at least every six months.

The panel determined, on the balance of probability, Miss Fallowfield did not ensure that a care plan was in place for Patient A despite there being a requirement for her to do so as Patient A's Care Co-ordinator.

This charge is therefore found proved.

Charge 3.2

3. In relation to Patient A:

3.2 Did not ensure that that a risk assessment was in place.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2 and Witness 3's oral and written evidence along with Patient A's care notes. .

Witness 2 in her evidence took the panel through the policy and procedure for risk assessment of patients. She told the panel that as a CPN you would assess risk on every occasion that you had contact with a patient, however formal risk assessments should be conducted whenever there was a change in circumstances. She told the panel that Patient A's discharge from inpatient services would be a change of circumstance that would require an updated risk assessment.

The panel had regard to Patient A's care notes and established that there was no risk assessment documentation present whilst under the care of Miss Fallowfield.

The panel noted that risk assessments were completed electronically at that time (GRiST) but had assurances from Witness 2 and Witness 3 that the procedure at the time was that this would be printed off and stored within the patient's file in order that anyone involved with their care had access to these documents.

Having regard to Patient A's care notes the panel was satisfied that there was no risk assessment in place despite Patient A being high risk and having previous, recent attempts at suicide.

The panel determined, on the balance of probability, Miss Fallowfield did not ensure that a risk assessment was in place for Patient A despite there being a requirement for her to have done so as Patient A's Care Co-ordinator.

This charge is therefore found proved.

Charge 3.3

3. In relation to Patient A:

3.3 Did not carry out a follow up visit as required within 7 days from ~~22~~ **17** July 2014, being the date of the patients discharge.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, the Interim Discharge Summary for Patient A, Patient A's care notes, and the 'Guidance on delivery of the Care Programme Approach' document.

Witness 2 told the panel that on discharge from an inpatient facility to the care of RaST a patient was required to be visited within seven days. Witness 2 told the panel that this was important to see how a patient was adjusting to the change in their circumstances and no longer being cared for as an inpatient.

The panel noted the Interim Discharge Summary for Patient A which lists Miss Fallowfield as the Care Co-ordinator and under the hearing discharge plan clearly states '*7 day follow up by Care Coordinator'*. The date of discharge was given as 17 July 2014. This document was sent to Miss Fallowfield.

The panel noted that in Patient A's care notes, dated 17 July 2014 there are details of the CPA meeting and Miss Fallowfield is listed as being in attendance. This entry also confirms a seven day follow up was arranged for 22 July 2014. The panel considered that, as Miss Fallowfield was present at this meeting she would have been aware of the seven day follow up arrangements. There is no record in the patient care notes of a follow up visit by Miss Fallowfield within seven days of Patient A's discharge.

The next entry in Patient A's care notes is dated 28 July 2014 and contains details of a telephone call from a relative of Patient A who was concerned about Patient A's health and was not happy that Patient A could not be seen by the team until the following afternoon.

The panel had regard to the 'Guidance on delivery of the Care Programme Approach' document which states '*Direct contact following any form of discharge from an in-patient unit will be within seven days.*' In addition The Trust's Discharge and Transfer Policy for the relevant time states '*All patients discharged and still in receipt of care and treatment will receive follow up within 7 days of discharge or sooner if warranted within the clinical*

risk assessment, (24 – 48 hours) this can be undertaken either by face to face contact or over the telephone based on the Clinical Risk profile of the patient. Care plans for people who are at high risk of suicide will require more intensive support for the first 3 months following discharge from in-patient care.'

The panel considered that Miss Fallowfield had a duty, under these policies and as Patient A's Care Co-ordinator, to conduct a follow up visit with Patient A within seven days of their discharge.

From a detailed examination of Patient A's care notes, the panel could see no evidence that Miss Fallowfield had conducted the required follow up visit.

The panel determined that, on the balance of probability, Miss Fallowfield did not carry out a follow up visit as required within seven days of Patient A's discharge on 17 July 2014.

The panel therefore found this charge proved.

Charge 3.4

3. In relation to Patient A:

3.4 Between 22 July 2014 and 22 October 2014 did not document and/or visit the patient as required.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient A's care notes.

Witness 2 told the panel that the only entry she found in Patient A's care notes after 17 July 2014 was dated 28 July 2014 and was regarding a telephone call received by another CPN in which Patient A's relative expressed concerns about Patient A's health. She said that there was no evidence that Miss Fallowfield had visited Patient A following their discharge from inpatient care on 17 July 2014 and 22 October 2014.

Following a detailed examination of Patient A's care notes the panel concluded there was no documentation of Miss Fallowfield visiting Patient A between 22 July 2014 and 22 October 2014. The panel noted that the date of 22 October 2014 was when the investigation into Miss Fallowfield's practice commenced. The panel accepted that, as Patient A's Care Co-ordinator, Miss Fallowfield would have had a duty to visit them and to document any contact she had with Patient A.

The panel determined that Miss Fallowfield did not document or visit Patient A as required between 22 July 2014 and 22 October 2014.

The panel therefore found this charge proved.

Charge 4.1

4. In relation to Patient B:

4.1 Did not carry out a follow up visit as required within 7 days from the ~~7 April~~ **16 March** 2015 being the date of discharge.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, the Interim Discharge Summary for Patient B dated 16 March 2015, Patient B's Discharge Summary dated 7 April 2015, letters dated 14 July 2015 and 17 July 2015 from Patient B's

Consultant Psychiatrist, Patient B's care notes, and the 'Guidance on delivery of the Care Programme Approach' document.

Prior to making any findings in respect of the charges relating to Patient B, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient B.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient B. She told the panel that Miss Fallowfield was allocated to Patient B as their CPN/Care Co-ordinator on 12 March 2015.

The panel had regard to a letter dated 14 July 2015 from Patient B's Consultant Psychiatrist which included details of an assessment of Patient B on 18 June 2015 at which Miss Fallowfield was present. A further letter also from Patient B's Consultant Psychiatrist dated 17 July 2015 relates to discussion with Miss Fallowfield as Patient B's CPN on 29 June 2015. Further, the Discharge Summary dated 7 April 2015 listed Miss Fallowfield as Patient B's Care Co-ordinator.

The panel was therefore satisfied that Miss Fallowfield was the allocated CPN and Care Co-ordinator for Patient B at the relevant time.

The panel reminded itself of the criteria set out at charge 1.1 in respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield as the allocated Care Co-ordinator. Being satisfied that Miss Fallowfield had an obligation in respect of Patient B the panel moved on to consider charge 4.1.

Witness 2 told the panel that Miss Fallowfield should have conducted a seven day follow up for Patient B as per Trust policy and that this was important for Patient B's safety and wellbeing.

The Interim Discharge Summary for Patient B dated 16 March 2015 lists Miss Fallowfield as the Care Co-ordinator and under the hearing discharge plan clearly states ‘7 day follow up by Care Coordinator’. This letter was copied to Miss Fallowfield.

The panel reminded itself of the ‘Guidance on delivery of the Care Programme Approach’ document and The Trust’s Discharge and Transfer Policy for the relevant time which gives guidance on follow up visits following discharge as detailed at charge 3.3 above.

The panel considered that Miss Fallowfield had a duty, under these policies and as Patient B’s Care Co-ordinator, to conduct a follow up visit with Patient B within seven days of their discharge.

From a detailed examination of Patient B’s care notes, the panel could see no evidence that Miss Fallowfield had conducted the required follow up visit, despite evidence that she had a duty to do so and must have been aware of this.

The panel determined that, on the balance of probability, Miss Fallowfield did not carry out a follow up visit as required within seven days of Patient B’s discharge on 16 March 2015.

The panel therefore found this charge proved.

Charge 4.2

4. In relation to Patient B:

4.2 Did not ensure that the patient’s notes were kept in chronological order.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient B's care notes.

Witness 2 told the panel that when she had reviewed Patient B's care notes that they were very difficult to follow and did not provide a clear plan of care. She said she would have expected Miss Fallowfield to have managed the records and ensure they were in chronological order.

The panel had regard to Patient B's care notes which total over 700 pages. The panel was of the view that the notes are chaotic. However, it considered that the majority of the notes relate to Patient B's inpatient care and it has no evidence to say that the notes arrived from the inpatient unit in chronological order. Further, the panel noted that other professionals would have had access to these notes. The panel considered it would be inappropriate to hold Miss Fallowfield responsible for the poor chronological order of Patient B's notes given that there is no evidence that it was her responsibility to ensure notes for previous care were kept in order.

The panel therefore found this charge not proved.

Charge 4.3, 4.4, 4.5 and 4.6

4. In relation to Patient B:

4.3 Did not put a care plan in place.
4.4 Did not complete care records.
4.5 Did not complete a risk assessment.
4.6 Did not complete a CPA review.
4.7 Did not formulate a risk and relapse plan.

The panel decided to consider charges 4.3, 4.4, 4.5, 4.6 and 4.7 together.

These charges are all found proved.

In reaching this decision, the panel took into account Witness 2 and Witness 3's evidence, the letters dated 14 July 2015 and 17 July 2015 from Patient B's Consultant Psychiatrist, the Lorenzo spreadsheet, Patient B's care notes, and the 'Guidance on delivery of the Care Programme Approach' document.

Having reminded itself of the 'Guidance on delivery of the Care Programme Approach' policy and the responsibilities of a Care Co-ordinator the panel was satisfied that Miss Fallowfield was under an obligation to put a care plan in place (charge 4.3), to complete care records (charge 4.4), to complete a risk assessment (charge 4.5) and a CPA review (charge 4.6) and to formulate a risk and relapse plan (charge 4.7).

The panel noted that whilst there were entries in the Lorenzo spreadsheet indicating that Miss Fallowfield had scheduled contact with Patient B there is nothing in the patient care notes to support that the scheduled meetings on 18 June and 13 July 2015 regarding a CPA review including care planning actually took place (charge 4.3 and 4.6).

The panel noted that, despite evidence that Miss Fallowfield was present at Patient B's review with the Consultant Psychiatrist on 18 June 2015 and had a discussion with the Consultant Psychiatrist on 29 June 2015 she has not documented either of these in Patient B's care notes (charge 4.4).

In respect of the risk assessment the panel heard evidence that risk assessments were completed electronically at that time (GRiST) but had assurances from Witness 2 and Witness 3 that the procedure at the time was that this would then be printed off and stored in the patient's file. The panel considered that Miss Fallowfield had a responsibility to ensure any electronic records were kept with the patient notes so that the multidisciplinary team has access to all relevant documents when looking at the patient notes.

From a detailed examination of Patient B's care notes, the panel could see no evidence that a care plan (charge 4.3), risk assessment (Charge 4.5), CPA review (charge 4.6) or a risk and relapse plan (charge 4.7) had been conducted, formulated or completed by Miss Fallowfield.

Given the absence of this documentation the panel determined on the balance of probability, Miss Fallowfield did not complete or formulate the documents as detailed.

The panel therefore found charges 4.3, 4.4, 4.5, 4.6 and 4.7 proved.

Charge 4.8

4. In relation to Patient B:

4.8 Between ~~7 April~~ **16 March** 2015 and 30 August 2015 did not document and/or visit the patient as required.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, the Lorenzo spreadsheet, the letters dated 14 July 2015 and 17 July 2015 from Patient B's Consultant Psychiatrist, the 'Guidance on delivery of the Care Programme Approach' document and Patient B's care notes.

Whilst there is evidence that Miss Fallowfield attended an outpatient meeting with Patient B and their Consultant Psychiatrist on 18 June 2015, there are no entries by Miss Fallowfield in Patient B's care notes pertaining to the period 16 March 2015 (when Patient B was discharged from an inpatient facility) and 30 August 2015 (when Patient B was admitted to an inpatient facility). The panel noted there is a requirement under the

‘Guidance on delivery of the Care Programme Approach’ policy that the allocated Care Co-ordinator should be visiting patients in their home on a regular basis.

The panel noted that whilst there were entries in the Lorenzo spreadsheet indicating that Miss Fallowfield had scheduled contact with Patient B on 20 March, 18 May, 18 June 13 July and 30 August 2015 there is nothing in the patient care notes to support that these meetings took place.

Given the lack of entries in Patient B’s notes between 16 March 2015 and 30 August 2015 the panel determined that, on the balance of probability, Miss Fallowfield did not document or visit Patient B as required.

This charge is therefore found proved.

Charge 5.1.1

5. In relation to Patient C:

5.1 Between July 2014 and October 2015

5.1.1 Did not document and/or visit the patient.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2’s evidence, a discharge letter dated 11 September 2012 from Patient C’s Consultant Psychiatrist, Patient C’s care notes, and the ‘Guidance on delivery of the Care Programme Approach’ document.

Prior to making any findings in respect of the charges relating to Patient C, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient C.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient C. She told the panel that Miss Fallowfield was allocated to Patient C as their CPN on 17 January 2012. However, Patient C was an inpatient at this time and was not discharged until 29 August 2012 when Miss Fallowfield became responsible for their care.

The panel had regard to the discharge letter dated 11 September 2012 from Patient C's Consultant Psychiatrist in which Miss Fallowfield is listed as their CPN. The panel noted that Miss Fallowfield had worked in the team for a considerable time and was the long-standing Care Co-ordinator for Patient C.

The panel was therefore satisfied that Miss Fallowfield was the allocated CPN and Care Co-ordinator for Patient C at the relevant time.

The panel reminded itself of the criteria set out at charge 1.1 in respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield at the time including the obligation to visit patients and to maintain clear and up to date records of patient's in her care.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient C the panel moved on to consider charge 5.1.1.

Witness 2 in her oral evidence took the panel through Patient C's notes. She told the panel that the notes were completed appropriately from Patient C's discharge from the inpatient unit in 2012 through to July 2014. However, from July 2014 through until the

investigation into Miss Fallowfield's practice commenced in October 2015 there was a complete absence of care notes.

From a detailed examination of Patient C's care notes, the panel could see no evidence that Miss Fallowfield had visited Patient C or documented this after the final entry in the notes which is dated 31 July 2014. The panel noted there was no line drawn under this entry to indicate that the patient notes continued elsewhere.

The panel considered that Miss Fallowfield was aware of her responsibility to visit Patient C and to document this in the patient care notes given that she had completed the notes appropriately from October 2012 to July 2014.

The panel determined that Miss Fallowfield did not visit or document visits to Patient C between July 2014 and October 2015.

The panel therefore found this charge proved.

Charge 5.1.2

5. In relation to Patient C:

5.1 Between July 2014 and October 2015

5.1.2 Did not document and/or carry out any CPA reviews.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient C's care notes, the Lorenzo spreadsheet and the 'Guidance on delivery of the Care Programme Approach'.

Witness 2 told the panel that there were no CPA reviews from July 2014 onwards in Patient C's care notes.

Having reminded itself of the 'Guidance on delivery of the Care Programme Approach' policy and the responsibilities of a Care Co-ordinator the panel was satisfied that Miss Fallowfield was under an obligation to carry out CPA reviews every six months.

The panel noted that whilst there were entries in the Lorenzo spreadsheet indicating that Miss Fallowfield had scheduled a CPA review including care planning with Patient C on 8 September 2014 there was nothing in the patient care notes to support that this took place. From a detailed examination of Patient C's care notes, the panel could see no evidence of a CPA review being carried out after July 2014. The last CPA review in Patient C's notes was conducted on 31 July 2013.

The panel determined that Miss Fallowfield did not document or carry out any CPA reviews between July 2014 and October 2015 when she would have been aware of her responsibility to do so at least every six months.

The panel therefore found this charge proved.

Charge 5.1.3

5. In relation to Patient C:

5.1 Between July 2014 and October 2015

5.1.3 Did not document and/or carry out any review meetings.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient C's care notes and the 'Guidance on delivery of the Care Programme Approach'.

Witness 2 told the panel that there were no review meetings from July 2014 onwards in Patient C's care notes.

Having reminded itself of the 'Guidance on delivery of the Care Programme Approach' policy and the responsibilities of a Care Co-ordinator the panel was satisfied that Miss Fallowfield was under an obligation to carry out review meetings.

From a detailed examination of Patient C's care notes, the panel could see no evidence of a review meeting being carried out after July 2014.

The panel determined that Miss Fallowfield did not document or carry out any review meetings between July 2014 and October 2015.

Although the panel therefore found this charge proved it noted that it was, to an extent, a duplication of charge 5.1.1. The panel therefore considered that finding this charge proved does not add to the seriousness of the charges.

Charge 5.1.4

5. In relation to Patient C:

5.1 Between July 2014 and October 2015

5.1.4 Did not document and/or carry out any revised care plans.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient C's care notes, the Lorenzo spreadsheet and the 'Guidance on delivery of the Care Programme Approach'.

Witness 2 told the panel that there were no revised care plans in Patient C's care notes after July 2014.

Having reminded itself of the 'Guidance on delivery of the Care Programme Approach' policy and the responsibilities of a Care Co-ordinator the panel was satisfied that Miss Fallowfield was under an obligation to formulate revised care plans.

The panel noted that whilst there were entries in the Lorenzo spreadsheet indicating that Miss Fallowfield had scheduled a CPA review including care planning with Patient C on 8 September 2014 there was nothing in the patient care notes to support that this took place. From a detailed examination of Patient C's care notes, the panel could see no evidence of an updated care plan after July 2014. The most recent care plan in Patient C's notes was dated 1 August 2013.

The panel determined that Miss Fallowfield did not document or carry out any revised care plans between July 2014 and October 2015 when she would have been aware of her responsibility to do so.

The panel therefore found this charge proved.

Charge 5.1.5

5. In relation to Patient C:

5.1 Between July 2014 and October 2015

5.1.5 Did not document and/or carry out an updated risk assessment.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient C's care notes and the 'Guidance on delivery of the Care Programme Approach'.

Witness 2 told the panel that there were no updated risk assessments in Patient C's care notes after July 2014.

Having reminded itself of the 'Guidance on delivery of the Care Programme Approach' policy and the responsibilities of a Care Co-ordinator the panel was satisfied that Miss Fallowfield was under an obligation to carry out and update Patient C's risk assessments.

From a detailed examination of Patient C's care notes, the panel could see no evidence of an updated risk assessment after July 2014.

The panel noted that the most recent risk assessment (GRiST) in Patient C's notes was dated 21 July 2014 in the header and footer however, the actual detail contained within this document appeared to be at least 12 months old relating to entries from 2012 and May 2013.

The panel determined that Miss Fallowfield did not document or carry out any updated risk assessments between July 2014 and October 2015 when she would have been aware of her responsibility to do so.

The panel therefore found this charge proved.

Charge 5.1.6

5. In relation to Patient C:

5.1 Between July 2014 and October 2015

5.1.6 Did not documents and/or carry out an updated relapse plan.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient C's care notes and the 'Guidance on delivery of the Care Programme Approach'.

Witness 2 told the panel that there was no updated Relapse and Risk Management form in Patient C's care notes after July 2014. She told the panel that this was an important document to ensure measures were in place should a patient's health condition relapse.

Having reminded itself of the 'Guidance on delivery of the Care Programme Approach' policy and the responsibilities of a Care Co-ordinator the panel was satisfied that Miss Fallowfield was under an obligation to carry out and update Patient C's Relapse and Risk Management form (relapse plan).

From a detailed examination of Patient C's care notes, the panel could see no evidence of an updated Relapse and Risk Management form after July 2014.

Whilst the panel had sight of documents from before 2014 showing that Miss Fallowfield understood what her responsibilities were towards Patient C in terms of having a relapse plan in place, there is nothing after July 2014 to indicate that Miss Fallow documented or carried out a relapse plan.

The panel therefore found this charge proved.

Charge 6.1, 6.2, 6.3 and 6.4

6. In relation to Patient D:

    6.1 Did not update the care plan as required.
    6.2 Did not document and/or visit the patient after 12 March 2015.
    6.3 Did not create/and or update a risk and relapse plan.
    6.4 Did not create/and or update a risk assessment.

The panel decided to consider these charges together.

These charges are all found proved.

In reaching this decision, the panel took into account Witness 2's evidence, a discharge letter, dated 16 November 2014, from the Speciality Doctor to the Psychiatric Intensive Care Unit (PICU) in respect of Patient D, Patient D's care notes, and the 'Guidance on delivery of the Care Programme Approach' document.

Prior to making any findings in respect of the charges relating to Patient D, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient D.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient D. She told the panel that Miss Fallowfield was allocated to Patient D as their CPN on 17 November 2014 when Patient D was discharged from PICU.

Witness 2 provided further evidence to the panel that Miss Fallowfield was the allocated Care Co-ordinator in the form of a discharge letter, dated 16 November 2014, from the

Speciality Doctor to PICU in respect of Patient D, which was copied to Miss Fallowfield, Care Co-ordinator.

The panel was therefore satisfied that Miss Fallowfield was the allocated CPN for Patient D at the relevant time.

The panel reminded itself of the criteria set out at charge 1.1 in respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield at the time.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient D the panel moved on to consider charge 6.1.

Having reminded itself of the 'Guidance on delivery of the Care Programme Approach' policy and the responsibilities of a Care Co-ordinator the panel was satisfied that Miss Fallowfield was under an obligation to update the care plan as required (charge 6.1), to document and visit the patient after 12 March 2015 (charge 6.2), to create or update a risk and relapse plan (charge 6.3) and to create or updated a risk assessment (charge 6.4).

Witness 2 in her oral evidence took the panel through Patient D's notes. She told the panel that the notes were initially completed to an acceptable standard. However, from 5 December 2014 there was a complete absence of patient care notes with the exception of a CPA review on 12 March 2015. Witness 2 indicated that she was surprised and concerned when she discovered this in her investigation of Miss Fallowfield's records. She explained that Patient D was a high risk patient with a history of suicide attempts. She told the panel that moving from an inpatient facility to living in the community under the care of RaST would be a significant change in circumstances for Patient D and it was therefore particularly important to keep risk assessments, relapse and risk plans and care plans up to date.

The panel noted that a CPA review was held on 12 March 2015 and Miss Fallowfield was present at this review and completed the care review form in respect of this. However, it noted that the review duration was 10 minutes. Witness 2 told the panel that this was poor as it would not be possible to properly review a high risk patient in this time; in addition a CPA review should be in consultation with other professionals involved in the patient's care and there was no evidence that this was done

From a detailed examination of Patient D's care notes, following the CPA review on 12 March 2015, the panel could see no evidence of any further entries in Patient D's notes. The panel noted that on 22 October 2015 there is an entry in Patient D's notes by Witness 1 which states *'Case file review as transferred from Jane Fallowfield's Case Load. No contact with Jane documented in file since discharged… CPA via telephone 12/3/15 with Jane…'*

Having had regard to letters from Patient D's Consultant Psychiatrist dated 18 June 2015 and 14 August 2014 (and copied to Miss Fallowfield) the panel was satisfied that Patient D remained an outpatient and would still be under the care of Miss Fallowfield and RaST.

The panel determined that on the balance of probability, Miss Fallowfield did not update Patient D's care plan as required (charge 6.1), did not document and/or visit the patient after 12 March 2015 (charge 6.2), did not create/and or update a risk and relapse plan (charge 6.3) and did not create/and or update a risk assessment (charge 6.4).

The panel therefore found charge 6.1, charge 6.2, charge 6.3 and charge 6.4 proved.

Charge 7.1

7. In relation to Patient E:

    7.1 Did not ensure that the patient had an up to date risk assessment.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, a letter from Patient E's Consultant Psychiatrist, dated 26 September 2014, Patient E's care notes, and the 'Guidance on delivery of the Care Programme Approach' document.

Prior to making any findings in respect of the charges relating to Patient E, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient E.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient E.

Witness 2 provided further evidence to the panel that Miss Fallowfield was the allocated CPN in the form of a letter from Patient E's Consultant Psychiatrist, dated 26 September 2014, which was copied to Miss Fallowfield, CPN. Further, there is documentation within Patient E's care notes which indicate Miss Fallowfield was their Care Co-ordinator.

The panel was therefore satisfied that Miss Fallowfield was the allocated Care Co-ordinator for Patient E at the relevant time.

The panel reminded itself of the criteria set out at charge 1.1 in respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield at the time.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient E the panel moved on to consider charge 7.1.

The panel had regard to the risk assessment (GRiST) for Patient E. Whilst this document is dated 26 July 2015 the contents of it appear to be outdated relating to entries in March 2014 and August 2012, and it is not signed by Patient E or Miss Fallowfield.

The panel concluded that, on the balance of probability, Miss Fallowfield did not ensure that Patient E had an up to date risk assessment.

The panel therefore found this charge proved.

Charge 7.2

7. In relation to Patient E:

7.2 Did not ensure that a care plan was in place.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient E's care notes.

Witness 2 told the panel that when she reviewed Patient E's notes she did not find a care plan apart from one dated 16 February 2016 which she believed was completed by Witness 1 who took over Patient E's care from Miss Fallowfield on 19 February 2016, however this document is unsigned. The panel was provided with Miss Fallowfield's absence record, which confirmed that she was absent from work from 14 October 2015.

From a detailed examination of Patient E's care notes the panel could not see any evidence of a care plan being in place from when Miss Fallowfield was allocated as Patient E's CPN on 26 September 2014.

The panel concluded that, on the balance of probability, Miss Fallowfield did not ensure that a care plan was in place for Patient E.

The panel therefore found this charge proved.

Charge 7.3.1 and 7.3.2

7. In relation to Patient E:

7.3 With regards to the CPA did not provide sufficient detail in that you did not;

7.3.1 Provide sufficient content.
7.3.2 Provide any outcome.

These charges are found proved.

In reaching this decision, the panel took into account Patient E's care notes.

The panel had regard to Patient E's care notes, in particular it noted an entry dated 19 September 2014 which states 'Picked Patient E up and brought her back to the Grange for outpatients and CPA review'. Whilst this entry indicates that Miss Fallowfield may have carried out a CPA review on 19 September 2014 there is no CPA review document contained within Patient E's care notes.

The panel determined that, on the balance of probability, the lack of a CPA document in Patient E's care notes satisfies both charges in that there is not sufficient content or any outcome detailed within Patient E's notes in respect of a CPA review.

The panel therefore found charges 7.3.1 and 7.3.2 proved.

Charge 8.1 and 8.2

8. In relation to Patient F:

8.1 Did not update the risk assessment since creating it on 31 January 2014.

8.2 Did not update a joint services review form since creating it on 4 March 2014.

These charges are found proved.

In reaching this decision, the panel took into account Witness 2's evidence, a letter from Patient F's Consultant Psychiatrist dated 4 July 2011, Patient F's care notes, and the 'Guidance on delivery of the Care Programme Approach' document.

Prior to making any findings in respect of the charges relating to Patient F, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient F.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the named Care Co-ordinator for Patient F. She told the panel that Miss Fallowfield was allocated to Patient F as their CPN on 8 July 2011.

Witness 2 provided further evidence to the panel that Miss Fallowfield was the allocated CPN in the form of a letter from Patient F's Consultant Psychiatrist, dated 4 July 2011.

The panel was therefore satisfied that Miss Fallowfield was the allocated CPN for Patient F at the relevant time.

The panel reminded itself of the criteria set out at charge 1.1 in respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield at the time.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient F the panel moved on to consider charges 8.1 and 8.2.

Witness 2 told the panel that Miss Fallowfield had completed a risk assessment on 31 January 2014 and a Joint Services Review form on 4 March 2014, however these would have been out of date by 2015 and would require updating. She told the panel that there were no updated risk assessment or Joint Services Review forms in Patient E's care notes after these dates. Although the panel did not have sight of these documents it accepted Witness 2's evidence that this was the case.

When questioned by the panel Witness 2 told the panel that the Joint Services Review form was the predecessor to the CPA review form and that the move to CPA's would have been around this time.

The panel noted that there is an entry in Patient F's care notes by Miss Fallowfield on 31 January 2014 which states '*Patient F attended for…CPA review… Please refer to CPA documentation for review details*'. The panel had regard to the Joint Services Review form for Patient E signed by Miss Fallowfield and dated 31 January 2014 and concluded that this was the CPA documentation referred to in the care notes. The panel noted that a risk assessment would be completed as part of the CPA review and was therefore satisfied on the balance of probability that Miss Fallowfield had created a risk assessment on 31 January 2014.

Witness 2 told the panel that the care notes for Patient F were regularly updated by Miss Fallowfield up until September 2015 at which time Patient F was allocated a new CPN.

The panel noted the Care Review Form for Patient F, dated 24 February 2015, which was completed by Miss Fallowfield and which did not appear to include a risk assessment.

The panel had regard to Patient F's care notes. In an entry dated 22 July 2015 Miss Fallowfield states *'GRiST [risk assessment] updated today…*', The panel acknowledged that the GRiST forms were electronic documents but reminded itself of Witness 2 and Witness 3's evidence that the procedure was to print these off and keep them in the patient notes, however the panel found no evidence of a risk assessment on 22 July 2015 in Patient F's care notes.

Having carefully reviewed Patient F's care notes, the panel was satisfied that there was no evidence of an updated risk assessment (charge 8.1) or a joint services review form (charge 8.2) after 31 January 2014. The panel consequently determined that Miss Fallowfield did not update the risk assessment and did not update a joint services review form for Patient F after creating them on 31 January 2014.

The panel therefore found charges 8.1 and charge 8.2 proved.

Charge 8.3

8. In relation to Patient F:

8.3 Did not assess the patient appropriately between 2014 and September 2015.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient F's care notes.

Witness 2 told the panel that Patient F's care notes indicated that Miss Fallowfield had visited Patient F on a regular basis to administer depot injections and that this would have been adequate.

The panel had regard to Patient F's care notes and noted that Miss Fallowfield had documented that she had seen Patient F 14 times in total in this time period. (30 September, 11 November, 25 November, 11 December 2014, 9 February, 24 February, 16 March, 31 March, 14 April, 29 April, 13 May, 25 June, 9 July, 23 July, 7 August, 8 October 2015). The panel acknowledged that most of these visits were to administer depot injections to Patient F but was aware that Witness 2, in her evidence, had conceded that you would assess a patient every time you saw them.

On examination of Patient F's notes between 2014 and 2015 it is clear to the panel that Miss Fallowfield was visiting Patient F on a regular basis. Although some entries only record an administration of the prescribed depot injection, several of the entries are more detailed and indicate that Miss Fallowfield was conducting appropriate assessment of Patient F.

The panel determined that, on the balance of probability, although Miss Fallowfield did not record any formal reviews such as the CPA review and joint services review, she was visiting Patient F and was clearly conducting appropriate assessment in her role as CPN.

The panel therefore found this charge not proved.

Charge 8.4

8. In relation to Patient F:

8.4 Did not update the care plan since May 2013.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient F's care notes, including the care plan dated 20 May 2013.

Witness 2 told the panel that during her investigation she had been concerned that she had not found an up to date care plan for Patient F. She told the panel that the only care plan in Patient F's notes was dated 20 May 2013. She told the panel that this was of concern because the care plan is the document which articulates a patient's needs and the actions necessary to address these.

From a detailed examination of Patient F's care notes the panel could not see any evidence of a care plan being updated from the care plan in the notes dated 20 May 2013.

The panel determined that, on balance of probability, Miss Fallowfield did not update Patient F's care plan since May 2013.

The panel therefore found this charge proved.

Charge 8.5

8. In relation to Patient F:

8.5 Did not update the CPA review.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient F's care notes and its findings at charge 8.2 above.

The panel noted that there is an entry in Patient F's notes dated 20 February 2014 in which Miss Fallowfield states '*CPA documentation placed in admin drawer…*'. However, there is no updated CPA document in Patient F's care notes.

When questioned by the panel Witness 2 told the panel that the Joint Services Review form was the predecessor to the CPA review form and that the move to CPA review would have been around this time.

The panel therefore considered that charge 8.5 was a duplication of charge 8.2. Consequently, having found charge 8.2 proved it followed that charge 8.5 must also be found proved.

Although the panel therefore found this charge proved it considered that this finding does not add to the seriousness of the charges.

Charge 8.6

8. In relation to Patient F:

8.6 Did not complete an AUDIT and Brief Screening

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient F's care notes.

Witness 2 told the panel that there were no AUDIT and Brief Screenings in Patient F's notes regarding the management of drugs and alcohol. She told the panel that because Patient F had alcohol issues it was a requirement that the AUDIT and Brief Screenings

should be completed to ensure that an awareness of the patient's alcohol use was understood.

From a detailed examination of Patient F's care notes the panel could not see any evidence that Miss Fallowfield had completed an AUDIT and Brief Screening despite evidence within the care notes that she was aware of Patient F's alcohol issues. The panel concluded that, on the balance of probability, Miss Fallowfield did not complete an AUDIT and Brief Screening in relation to Patient F.

The panel therefore found this charge proved.

Charge 8.7

8. In relation to Patient F:

8.7 Did not make it clear whether reports were submitted to the Ministry of Justice as requested.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient F's care notes.

Witness 2 in her witness statement said that it was unclear whether reports had been submitted as requested by the Ministry of Justice. She could not recall what document this would have been recorded on but stated that it would have been documented within Patient F's file. She could not confirm how frequently these reports should have been completed.

From a detailed examination of Patient F's care notes the panel could see entries by Miss Fallowfield on 20 February, 30 May, 11 September 2014 and 29 April 2015 which indicated that she had completed these reports and emailed them to the Ministry of Justice as requested.

The panel was satisfied that, whilst the reports were not contained in Patient F's notes, Miss Fallowfield made it clear within Patient F's notes that reports were submitted to the Ministry of Justice.

The panel therefore found this charge not proved.

Charge 9.1

9. In relation to Patient G:

9.1 Between October 2014 and March 2015 did not ensure that there was a second checker.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient G's Patient Front Sheet/Core information, Patient G's care notes and the Safe and Secure Handling of Medications Procedure for the Trust at the time.

Witness 2 confirmed that, as the allocated Care Co-ordinator, Miss Fallowfield would have been responsible for giving Patient G their depot injections. She told the panel that it was good practice that two professionals checked medication in and out, checking that it was the right dose for the prescription for Patient G.

Witness 2 explained that the Medication Balance Sheet was the Trust's way of recording the medication that was signed out. On the Medication Balance Sheet Miss Fallowfield signed out medication for Patient G on 10 October 2014, 7 November 2014, 21 November 2014, 16 January 2015, 30 January 2015, 20 February 2015, 6 March 2015 and 20 March 2015 but there was no countersignature on any of these entries. Witness 2 explained that this was of concern, particularly to have so many entries where it is not countersigned by a second checker. She told the panel that this was mandatory for controlled drugs but it was good practice for any medication being administered.

The panel noted that whilst the depot injection was not a controlled drug and therefore would not usually require a second checker, it was considered good practice within the Trust to have a second checker when removing medication. The panel noted that this is stated in the Safe and Secure Handling of Medications Procedure for the Trust at the time which states *'It is a good practice that, wherever possible, preparation and administration of medicines are checked by an Approved Witness.'*

The panel concluded that it appeared from the Medication Balance Sheet that Miss Fallowfield regularly removed medication for Patient G without ensuring there was a second checker and that this was considered to be against best practice within the Trust.

The panel therefore found this charge proved.

Charge 10.1

10. In relation to Patient H:

10.1 Between 20 March 2015 and 10 September 2015 did not keep the patients records in an orderly fashion.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient H's care notes which included Patient H's Relapse and Risk Management Plan, dated 18 September 2011 and various letters from Patient H's Consultant Psychiatrist (dated 27 December 2014, 7 January, 20 February, 22 June and 14 August 2015) and the 'Guidance on delivery of the Care Programme Approach' document.

Prior to making any findings in respect of the charges relating to Patient H, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient H.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient H. Patient H's Relapse and Risk Management Plan, dated 18 September 2011, lists Miss Fallowfield and Colleague A as Care Co-ordinator along with another Band 7 CPN. The panel noted that Miss Fallowfield is listed in various letters from Patient H's Consultant Psychiatrist (dated 27 December 2014, 7 January, 20 February, 22 June and 14 August 2015) as Patient H's CPN.

The panel was therefore satisfied that Miss Fallowfield was the allocated CPN for Patient H at the relevant time.

The panel reminded itself of the criteria set out at charge 1.1 in respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield at the time including the obligation to maintain clear and up to date records of patient's in her care.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient H the panel moved on to consider charge 10.1.

Witness 2 told the panel that Patient H was a high risk patient who had previously been in PICU and had had numerous admissions to hospital in the past.

In her evidence to the panel Witness 2 indicated that Miss Fallowfield's notes of Patient H's care were of an adequate standard between 2011 and 2015. She told the panel that her concerns related to Miss Fallowfield's record keeping from 2015 onwards.

Witness 2 highlighted that Patient H's care notes have entries which skip between months going backwards and forwards in time. Witness 2 told the panel that it looked as though the notes were not written contemporaneously, she said there were lots of ad hoc sheets when she conducted her investigation. She told the panel that the notes should go consecutively but that the dates skipped around and, in her opinion, looked like they had been written after the event. She said that there was no way that notes should be written months after and it should be clear that any non-contemporaneous notes were not written at the time.

From a detailed examination of Patient H's care notes the panel considered that throughout these notes there are numerous entries which are not recorded in date order.

The panel determined that, between 20 March 2015 and 10 September 2015, Miss Fallowfield did not keep Patient H's records in an orderly fashion.

The panel therefore found this charge proved.

Charge 10.2, 10.3, 10.4 and 10.5

10. In relation to Patient H:

10.2 Did not record and/or conduct a risk assessment.
10.3 Did not record and/or carry out a CPA review.
10.4 Did not record and/or carry out a risk and relapse plan.
10.5 Did not complete a care plan.

These charges are found proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient H's care notes.

Witness 2 told the panel that she had not been able to find a risk assessment or care plan within Patient H's care notes. She explained that the risk assessment was an important document to ensure that Patient H was safe, that their condition was being managed and that they had a care plan in place. She told the panel that she had not been able to find a CPA review within Patient H's record.

Witness 2 told the panel that the only Relapse and Risk Management plan she could find in the patient notes was completed whilst Patient H was an inpatient. She was not able to find an updated risk assessment after Patient H was transferred to community care with Miss Fallowfield as their Care coordinator. She told the panel that there should have been an updated Relapse and Risk Management plan so that Patient H's care could be managed appropriately with the change in circumstances, moving from inpatient care to care in the community.

Witness 2 told the panel that she had taken a lot of time to ensure that she had not missed something in her investigation. She told the panel it was concerning that Patient H had been left without 'the fundamentals of care' and that without these documents the rest of the multidisciplinary team would not have the necessary information to inform Patient H's care. She said this was of particular concern in the case of Patient H who had a long history of violence aggression and unstable mental health.

The panel noted that the only Relapse and Risk Management plan was completed when Patient H was an inpatient.

From a detailed examination of Patient H's care notes, the panel could see no evidence within the care notes that Miss Fallowfield had recorded or carried out a risk assessment (charge 10.2), CPA review (charge 10.3) a Relapse and Risk Management plan (charge 10.4) or a care plan (charge 10.5).

In light of this the panel determined that, on the balance of probability, in relation to Patient H, Miss Fallowfield did not record or conduct a risk assessment (charge 10.2), did not record or carry out a CPA review (charge 10.3), did not record or carry out a risk and relapse plan (charge 10.4) and did not complete a care plan (charge 10.5) despite there being a responsibility for her to do so in her position as Patient H's allocated Care Co-ordinator and CPN.

The panel therefore found charge 10.2, 10.3, 10.4 and 10.5 proved.

Charge 10.6

10. In relation to Patient H:

10.6 Did not visit the patient as required.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's evidence, Witness 2's evidence and Patient H's care notes.

Colleague A told the panel that he would visit Patient H every two to three weeks in his capacity of Care Officer, and that Miss Fallowfield generally visited once a month.

Witness 2 told the panel that from going over Patient H's care notes that there was evidence that Miss Fallowfield had visited Patient H at home.

The panel had regard to the Patient H's care notes. It noted that Miss Fallowfield had recorded visiting Patient H at home in March, April, June, July, September and October 2015, with other records of attempted visits in between (notably there were two attempted visits in August). There were further notes of her contact with him at outpatient meetings and by telephone as well as notes from other CPN's visiting him when Miss Fallowfield was on leave.

The panel considered that there was clear evidence within Patient H's notes which records Miss Fallowfield visiting Patient H. The panel has no evidence to suggest that these entries are false.

The panel determined that, on the balance of probability, Miss Fallowfield did visit Patient H as required.

The panel therefore found this charge not proved.

Charge 10.7

10. In relation to Patient H:

10.7 On one or more occasions told colleague A that you had visited the patient when you had not.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2 and Colleague A's evidence, Patient H's care notes and its findings in respect of charge 10.6 above.

Witness 2 told the panel that from going over Patient H's care notes that there was evidence that Miss Fallowfield had visited Patient H at home. Colleague A told the panel that he became aware that Miss Fallowfield had missed a visit with Patient H.

Colleague A told the panel that Patient H had disclosed to him that he had not seen Miss Fallowfield. Colleague A told the panel that he had been surprised by this as he thought she was visiting Patient H regularly. He told the panel that Miss Fallowfield had told him that she had been to visit Patient H.

The panel considered that this charge was a case of accepting one person's version over that of another. On the one hand Colleague A has told the panel that Patient H told him that he had not seen Miss Fallowfield. On the other hand when Colleague A asked Miss Fallowfield about this she told him that she had seen Patient H. The panel noted that Colleague A, in his evidence, could not recall a specific date when this instance occurred. Neither Miss Fallowfield nor Patient H have given direct evidence to the panel in respect of this charge.

The panel noted that within Patient H's care notes their state of mind has been described as confused at times as a result of their mental health condition. The panel was therefore cautious in relying on this evidence, particularly with it being provided as second hand evidence via Colleague A.

The panel has already found, as a matter of fact at charge 10.6, that Miss Fallowfield had visited Patient H as required. The panel considered that there was no evidence that Miss Fallowfield had not visited Patient H nor that the entries relating to these entries within the patient care notes were false.

Whilst the panel considered Colleague A a credible witness, it considered that his evidence in respect of this charge was somewhat vague and less reliable. On careful review of his written witness statements the panel considered some of his evidence was

confusing. The panel was not satisfied that it could solely rely on Colleague A's evidence in respect of this charge.

The panel considered that this charge, leading to a charge of dishonesty at 10.8, was particularly serious. Whilst the standard of proof remained the same it considered that it required particularly cogent evidence to enable it to find this charge proved. The panel was not satisfied that, on balance of probability, it could find this charge proved on the basis of the evidence provided. As a result the panel determined that there was not sufficient evidence to conclude that, on one or more occasions, Miss Fallowfield told Colleague A that she had visited Patient H when she had not.

The panel therefore found this charge not proved.

Charge 10.8

10. In relation to Patient H:

10.8 Your actions at charge 10.7 were dishonest in that you sought to create the impression that you had visited the patient when you knew that you had not.

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings at charge 10.7.

Having found charge 10.7 not proved this charge falls away.

The panel therefore found this charge not proved.

Charge 11.1.1 and 11.1.2

11. In relation to Patient I:

11.1 Did not sign the following care plans;

11.1.1 December 2015.
11.1.2 September 2016.

The panel considered charge 11.1.1 and 11.1.2 together.

These charges are found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient I's care notes with a letter from Patient H's Consultant Psychiatrist dated 7 November 2012 and the 'Guidance on delivery of the Care Programme Approach' document.

Prior to making any findings in respect of the charges relating to Patient I, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient I.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient I. She told the panel that this was confirmed by the letter from Patient I's Consultant Psychiatrist, dated 24 June 2014, which was copied to Miss Fallowfield, CPN.

The panel was therefore satisfied that Miss Fallowfield was the allocated CPN for Patient I at the relevant time.

The panel reminded itself of the criteria set out at charge 1.1 in respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield in respect of Patient I.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient I the panel moved on to consider charge 11.1.

Witness 2 confirmed to the panel that she had identified six care plans on file for Patient I dated June 2013, May 2014, December 2014, March 2015, December 2015 and September 2016. She told the panel that the care plans in December 2015 and September 2016 were not signed and that she would have expected these to be signed by the Care Co-ordinator and Patient I.

The panel had regard to Patient H's care plan for December 2015. It noted that the Care Co-ordinator is recorded as another CPN (Colleague B), not Miss Fallowfield. The panel next reviewed Patient H's care plan dated September 2016. Again it noted that the Care Co-ordinator was recorded as Colleague B rather than Miss Fallowfield. Further the Care Review Form dated 13 November 2015 records a change of CPN from Miss Fallowfield to Colleague B.

The panel next had regard to Miss Fallowfield's absence record. This records that Miss Fallowfield was absent from 14 October 2015 to 9 September 2016. The panel considered that as Miss Fallowfield was absent from work during this time she would not have been responsible for signing the care plans dated December 2015 and September 2016.

In addition the panel concluded that Miss Fallowfield was no longer the allocated CPN for Patient I in December 2015 (charge 11.1.1) or September 2016 (charge 11.1.2), as is evident by Colleague B being the named CPN on these care plans. Therefore she would not have been responsible for Patient I's care at this time and would not be required to sign the care plans.

The panel therefore found charge 11.1.1 and charge 11.1.2 not proved.

Charge 11.2

11. In relation to Patient I:

11.2 When completing the care plan in May 2014 copied the care plan for 2013.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient I's care notes.

Witness 2 told the panel that when she reviewed Patient I's care plans she noted that the care plan for May 2014 seemed to be an exact copy of the care plan from 2013. Witness 2 told the panel it looked like the care plan for 2013 had been cut and pasted into the care plan document for May 2014 as there were no entries over the previous year. Witness 2 accepted that there might not be a significant change to a patient's care plan, but she said that something should have changed over the year and if nothing had changed then you should be asking why it has not. She told the panel that it was concerning that the care plans were exactly the same.

The panel had regard to Patient I's care plan for 25 May 2014 and 24 June 2013. Upon careful examination of these care plans the panel concluded that these would appear to be almost identical. It noted that the care plan for May 2014 included the date signed in type as 24 June 2013 which had been scored through by Miss Fallowfield and the date of 24 May 2014 inserted. All of the dates in the care plan document for May 2014 are dated 24 June 2013.

The panel concluded, on the balance of probability, that when completing the care plan for Patient I in May 2014 Miss Fallowfield copied the care plan for 2013.

This charge is therefore found proved.

Charge 11.3

11. In relation to Patient I:

11.3 Did not carry out a proper assessment of the patient when completing the care plan in May 2014.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence and Patient I's care notes along with its findings at charge 11.2.

Witness 2, in her oral evidence, said that in her opinion Miss Fallowfield appeared not to have carried out a proper assessment of Patient I if she had just copied over the details from the previous year. Witness 2 acknowledged that changes might be minimal over the course of a year but said that an exact copy would be unusual as circumstances and health was likely to have changed over a year.

The panel considered that it was clear that Miss Fallowfield had copied the care plan for 2013 when completing the care plan in 2014 as it has found at charge 11.2. The panel considered that this indicated that there had been no proper assessment of Patient I carried out or documented by Miss Fallowfield.

The panel determined that, on the balance of probability, Miss Fallowfield did not carry out a proper assessment of the patient when completing the care plan in May 2014.

The panel therefore found this charge proved.

Charge 12.1

12. In relation to Patient J:

12.1 Were not clear whether you had completed the risk and relapse plan and/or care plan dated 16 January 2015.

This charge is found proved in respect of the non-completion of the care plan.

In reaching this decision, the panel took into account Witness 2's evidence, Patient I's care notes and the 'Guidance on delivery of the Care Programme Approach' document.

Prior to making any findings in respect of the charges relating to Patient J, the panel first had to establish whether Miss Fallowfield had an obligation to provide the care to Patient J.

Witness 2 told the panel that she was not aware of when Miss Fallowfield was allocated to Patient J but that she had concluded that she was Patient J's CPN due to the frequency of her entries in Patient J's care notes and her completion of the care plans for Patient I.

The panel had regard to the Relapse and Risk Management Plan dated 16 January 2015 on which Miss Fallowfield is named as Patient J's Care Co-ordinator.

The panel was therefore satisfied that Miss Fallowfield was the allocated CPN for Patient J at the relevant time.

The panel considered the 'Guidance on delivery of the Care Programme Approach' document and concluded that Miss Fallowfield had completed the paperwork appropriate to the role of the allocated CPN. It reminded itself of the criteria set out at charge 1.1 in

respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient J the panel moved on to consider charge 12.1.

The panel had regard to the Relapse and Risk Management Plan (risk and relapse plan) dated 16 January 2015 which was completed and signed by Miss Fallowfield. The panel therefore considered that this part of the charge was not proved as there was clear evidence that Miss Fallowfield had completed the risk and relapse plan.

The panel had regard to the Mental Health Service Plan (care plan) for Patient J dated 16 January 2015. The panel noted this was not signed by Miss Fallowfield. The panel therefore concluded that Miss Fallowfield was not clear whether she had completed the care plan dated 16 January 2015 as this document should have be signed by her and was not.

The panel therefore found this charge proved in respect of the care plan but not proved in respect of the risk and relapse plan.

Charge 12.2

12. In relation to Patient J:

12.2 Did not document and/or communicate with the patient's GP.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence along with Patient J's care notes.

Witness 2 told the panel that from her investigation of Patient J's care notes she had concluded that there was no correspondence between Miss Fallowfield and Patient J's GP. She told the panel that it was good practice to have regular correspondence between a patient's CPN and GP.

The panel noted that Miss Fallowfield had made an entry in Patient J's care notes on 13 March 2015 saying that she had contacted the GP practice. However, the panel considered that this was to arrange for the administration of depot medication by the practice nurse and was not the same as speaking to the GP.

From a detailed examination of Patient J's care notes, the panel could see no documentation or evidence that Miss Fallowfield had communicated with Patient J's GP.

The panel therefore determined that, on the balance of probability, Miss Fallowfield did not document and/or communicate with Patient J's GP.

The panel therefore found this charge proved.

Charge 12.3

12. In relation to Patient J:

12.3 Did not follow up with the patient between March 2015 to October 2015.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence along with Patient J's care notes.

The panel had regard to Patient J's care notes. The last entry by Miss Fallowfield is dated 3 March 2015. In this entry Miss Fallowfield stated: '*Contacted Patient J's GP practise to try and arrange for the nurse to do Patient J's depot injection in the future, I was unable to get through. I rang Patient J and she told me that she had already made an appointment with the practise nurse for Tuesday 10 March 2015. I agreed to contact Patient J next week to make sure she was alright and then we would agree via a CPA whether to discharge her or not (sic)'*.

The panel noted that the practice nurse had been giving Patient J their depot injection on a monthly basis since March 2015.

Witness 2 in her evidence told the panel that if Patient J had been discharged Miss Fallowfield should have followed the correct policy (detailed previously at charge 1.10) which states that a CPA review with the multidisciplinary team should be conducted before a patient is discharged.

In her oral evidence to the panel Witness 4 confirmed the correct procedure which should be followed in discharging a patient from RaST. She told the panel that in the event of discharging a patient a CPA review should be completed with the multi-disciplinary team involved in the patient's care.

The panel noted that the formal discharge procedure is for a letter to go to the patient, the patient's consultant and the patient's GP. The panel noted there was no record of any such letters within Patient J's notes.

The panel concluded that Patient J was not discharged from RaST and that Miss Fallowfield retained a responsibility to conduct the relevant reviews and follow up Patient J's care on a regular basis.

From a detailed review of Patient J's notes the panel found no indication that Miss Fallowfield had any contact with Patient J after 3 March 2015 before the investigation into her practice commenced in October 2015.

The panel determined that, on the balance of probability, Miss Fallowfield did not follow up with Patient J between March 2015 to October 2015.

The panel therefore found this charge proved.

Charge 13.1

13. In relation to Patient L:

    13.1 Did not develop and/or complete ~~and~~ care plans

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Patient L's care notes which include two letters from Patient L's previous Care Co-ordinator dated 24 April 2012 and the 'Guidance on delivery of the Care Programme Approach' document.

Prior to making any findings in respect of the charges relating to Patient L, the panel first had to establish whether Miss Fallowfield had an obligation to provide care to Patient L.

The panel had regard to Witness 2's oral and written evidence in which she stated that Miss Fallowfield was the allocated CPN for Patient L. She told the panel that Miss Fallowfield was allocated to Patient L as their CPN on 24 April 2012.

Witness 2 provided further evidence to the panel that Miss Fallowfield was the allocated CPN in the form of a letter from Patient L's previous Care Co-ordinator dated 24 April

2012 to Patient L's GP, which stated that Patient L's care co-ordination was being transferred to Miss Fallowfield, CPN. Patient L was also sent a letter detailing the same on 24 April 2012.

The panel was therefore satisfied that Miss Fallowfield was the allocated Care Co-ordinator for Patient L at the relevant time.

The panel reminded itself of the criteria set out at charge 1.1 in respect of the role and responsibilities of the allocated Care Co-ordinator and was satisfied that there was clear guidance on the role and responsibility of Miss Fallowfield at the time including the obligation to maintain clear and up to date records of patients in her care.

Being satisfied that Miss Fallowfield had an obligation in respect of Patient L the panel moved on to consider charge 13.1.

Witness 2 told the panel that from her investigation into Miss Fallowfield's practice, she had been unable to find any care plans for Patient L in their care notes.

From a detailed review of Patient L's notes the panel found no indication that Miss Fallowfield had completed a care plan for Patient L. The panel was satisfied that, as Patient L's Care Co-ordinator, Miss Fallowfield had a responsibility to ensure that a care plan was in place and was kept up to date as detailed in previous charges.

The panel determined that, on the balance of probability, Miss Fallowfield did not develop or complete care plans for Patient L.

This charge is therefore found proved.

Charge 13.2

13. In relation to Patient L:

13.2 Did not carry out any assessments and/or any risk assessments.

This charge is found proved in respect of did not carry out any risk assessments.

In reaching this decision, the panel took into account Witness 2's evidence and Patient L's care notes.

Witness 2 told the panel that from her investigation into Miss Fallowfield's practice, she had been unable to find any assessments or risk assessments for Patient L in their care notes during the time Miss Fallowfield was their allocated CPN.

The panel had regard to Patient L's care notes. It considered that there were various entries in the care notes which indicated that Miss Fallowfield had visited Patient L on numerous occasions. As per the previous evidence of Witness 2 the panel accepted that Miss Fallowfield would have carried out an assessment of Patient L's needs and a risk assessment on each visit, recognising that this would not always be a formal assessment but an assessment of Patient L's presentation at the time. The panel noted that there are several comprehensive entries within the care notes where it is clear that Miss Fallowfield did carry out an assessment of Patient L. The panel therefore considered that Miss Fallowfield did carry out assessments of Patient L and so found this part of the charge not proved.

However, from the detailed review of Patient L's notes the panel found no indication that Miss Fallowfield had completed a risk assessment for Patient L. The panel was satisfied that, as Patient L's Care Co-ordinator, Miss Fallowfield had a responsibility to ensure that a risk assessment was in place and was kept up to date as detailed in previous charges.

In light of the above, the panel determined that, whilst there was evidence in Patient L's care notes that Miss Fallowfield carried out a number of assessments of Patient L, there was no evidence that she carried out any formal risk assessments.

The panel therefore found this charge proved in respect of the risk assessments but not proved in respect of any assessments.

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 Miss Fallowfield's 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, Miss Fallowfield's 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.'*

Mr Edwards invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of The Code: Standards of conduct, performance and ethics for nurses and midwives 2008' (the 2008 Code) and The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the 2015 Code) in making its decision.

Mr Edwards identified the specific, relevant standards in the 2008 Code and the 2015 Code where Miss Fallowfield's actions amounted to misconduct.

Mr Edwards submitted that Miss Fallowfield was an experienced CPN, with high risk patients in her care, and that she would have known the importance of conducting assessments. He reminded the panel of its findings that Miss Fallowfield had failed to maintain contact with patients in her care who were relying on her input to remain safe and well in the community, that she had incorrectly stored patient notes and that her medication management and record-keeping were lacking. He submitted that she had put patients at a real risk of harm and it was a matter of luck that no harm came to her patients.

Mr Edwards submitted that Miss Fallowfield's practice had fallen well below the standard expected of a nurse and reminded the panel that she was not only in charge of managing her own caseload but as team leader would have been responsible for managing the work of junior staff. He told the panel that she was expected to be a role model and that she had failed to correctly lead her team and set a good example as well as the failure to adequately care for patients on her caseload.

Mr Edwards submitted that the charges found proved fell well below the standards expected of a nurse of Miss Fallowfield's experience and calibre and that they, both individually and cumulatively, amounted to misconduct.

Submissions on impairment

Mr Edwards 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 *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Edwards submitted that the first three limbs of the test set out in the case of *Grant* were engaged in this case. He submitted that Miss Fallowfield's general written response to the charges provided no evidence of remediation in respect of the failings identified. He submitted that, whilst the panel had a mitigation statement from Miss Fallowfield dated 9 January 2017, there was nothing before it in terms of any reflection or training undertaken. He submitted that although there could be said to be limited insight it was insufficient to consider her practice not currently impaired.

Mr Edwards invited the panel to consider whether the conduct is capable of remediation, whether it has been remediated, and whether Miss Fallowfield's actions are likely to be repeated in the future. He submitted that due to the lack of insight there was a real risk of repetition should Miss Fallowfield be in a similar position in future.

Mr Edwards submitted that Miss Fallowfield's failures were extremely serious, involving failings across all levels of care to all patients who were reliant on her to provide care. He

submitted that other nurses would be shocked and appalled by Miss Fallowfield's actions as demonstrated by Witness 2 in her evidence. He submitted that public confidence in the NMC would be undermined should there be a finding of no impairment.

Mr Edwards submitted that Miss Fallowfield was currently impaired on both public protection and public interest grounds.

Miss Fallowfield's mitigation statement dated 9 January 2017 detailed various health issues and the impact that these had on her work as well as references to tensions within the wider team. She has also recognised and accepted responsibility for several of her failings. She stated '*I accept that my documentation was poor and not filed, there was some client information in the electronic folders and acknowledge that I should have printed it all out and filed it. I acknowledge that I should have disposed of the boxes of consta the needles were Automatically (sic) sheaved but I had forgotten to remove them from my desk after I had emptied a depot case and know this is unacceptable*.'

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Cohen* 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 2008 Code and the 2015 Code.

The panel was of the view that Miss Fallowfield's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Fallowfield's actions amounted to a breach of various aspects of both the 2008 Code and the 2015 Code. Specifically:

2008 Code

- **Collaborate with those in your care**
- **Share information with your colleagues**
- **Work effectively as part of a team**
- **Manage risk**
- **Keep clear and accurate records**
- **Uphold the reputation of your profession**

2015 Code

1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

8 Work co-operatively

8.2 maintain effective communication with colleagues

10 Keep clear and accurate records relevant to your practice

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.4 take all steps to keep medicines stored securely

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

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

20 Uphold the reputation of your profession at all times

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

The panel appreciated that breaches of the 2008 Code and the 2015 Code do not automatically result in a finding of misconduct. However, the panel was of the view that the failings identified fell far below the standard of what was expected of a nurse, particularly an experienced nurse in a leadership role.

The panel considered that as a senior nurse in a management position Miss Fallowfield's role was to ensure all policy and procedures were adhered to not only by her team but by herself and by her failures she did not follow these.

The panel noted that the Care Programme Approach was brought into practice because of the need to have effective follow up and better co-ordinated care for patients with serious and enduring mental health problems in the community. Witness 2 told the panel that when mental health patients leave inpatient care to live in the community they are at an increased risk of suicide due to the increased stress, the change in circumstances and access to means. As the CPN and Care Co-ordinator Miss Fallowfield had a responsibility to monitor these highly vulnerable patients for signs of relapse. Most of her patients were high risk because of their mental health condition and were dependent on her for care.

The panel found that both individually and collectively Miss Fallowfield's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 *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 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 considered that the first three limbs of the '*Grant* test' were engaged in this case. The panel considered that the volume and wide-range of failings identified, relating to medication administration, care planning, CPA reviews, risk assessments and record-keeping for vulnerable patients were extremely serious and had put patients at an unwarranted risk of harm. It noted in particular Miss Fallowfield's failure to conduct seven day follow up visits with two separate patients upon their discharge from inpatient facilities into the community, when they would have been particularly vulnerable as detailed in the panel's decision on misconduct. It also noted its findings regarding Miss Fallowfield's failing to document what happened with medication which had been signed out may have resulted in a patient receiving a double dose of medication. The panel was of the view that it was a matter of luck that no patient had suffered actual harm as a result of Miss Fallowfield's failings.

The panel considered that Miss Fallowfield's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find the extensive range of charges, relating to vulnerable patients, extremely serious.

Regarding insight, the panel considered that Miss Fallowfield had demonstrated very limited insight. It noted her mitigation statement from January 2017 and her acceptance of

some of the failings in her practice. It noted that within this and in subsequent contact with the NMC, Miss Fallowfield has indicated that there may be reasons behind her misconduct, namely to do with her health, however without more cogent evidence the panel is unable to read anything further into this.

Further, the panel noted that Miss Fallowfield has not recognised the impact of her actions on her patients, their families, her colleagues and the wider profession.

The panel has heard evidence that Miss Fallowfield was an experienced nurse and had worked without issue for a significant time before the issues raised within these charges. Further, Witness 2 highlighted to the panel where she had found evidence that Miss Fallowfield's practice had been adequate and where she had delivered care appropriately. The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered whether or not Miss Fallowfield has remedied her practice. However, as Miss Fallowfield has not submitted a reflective piece regarding her practice and what she would do differently in future nor is there any evidence before the panel to demonstrate that Miss Fallowfield has undertaken training in the areas identified in the charges the panel concluded her practice has not yet been remedied.

Accordingly, the panel is of the view that there is a risk of repetition based on the lack of insight or remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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. It considered that the public and fellow professionals would be appalled to learn of Miss Fallowfield's failings and the risk of harm she put patients in her care at.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Fallowfield's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Fallowfield's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Fallowfield off the register. The effect of this order is that the NMC register will show that Miss Fallowfield has been struck-off the register.

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

Submissions on sanction

Mr Edwards, whilst recognising that the decision and sanction was for the panel alone, submitted that the NMC considered a striking-off order to be the appropriate sanction. Miss Fallowfield had been advised of this in the notice of hearing letter dated 8 April 2021.

Mr Edwards took the panel through the aggravating and mitigating factors, which, in the NMC's view, were present in this case.

Mr Edwards submitted that this was a serious case with repeated and wide-ranging failings involving a number of patients over a long period of time. He submitted that a conditions of practice order would not be appropriate as there are no workable conditions which would address the failings identified. He submitted that a striking-off order was the appropriate sanction to protect the public and address the public interest matters identified.

Decision and reasons on sanction

Having found Miss Fallowfield's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel acknowledged the NMC Sanction Bid of a striking-off order, but was not bound by such a bid, and has exercised its independent judgement. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and is intended to protect the patients and public by restricting the practice of a registered nurse. Although not intended to be punitive in its effect, any sanction may have such unintended consequences. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel has also taken account of the aggravating and mitigating factors in this case.

The aggravating factors which the panel took into account, in particular, were: the extensive, wide-ranging and repetitive nature of Miss Fallowfield's failings which related to basic nursing care; the particular vulnerability of Miss Fallowfield's patients and the real risk of patient harm (the panel considered it was a matter of luck that no harm came to her patients); the significant period of time over which the failings occurred (in excess of three years); Miss Fallowfield was an experienced nurse who was in a position of leadership and trust and had a duty to act as a role model for junior staff; and the lack of remediation

or insight. There is no indication that Miss Fallowfield appreciates the seriousness of her failings or the impact of these on her patients, their families, her colleagues or the wider profession.

The mitigating factors which the panel took into account were: there was no evidence of actual patient harm; there was some evidence of remorse; and Miss Fallowfield appeared to have accepted some of the failings and has accepted some responsibility for these albeit with qualifications and attempting to justify and shift blame for these failings. Further, the panel noted that there was evidence that Miss Fallowfield was an experienced, capable and competent nurse prior to these incidents.

The panel also took into consideration the alleged toxic work atmosphere, alleged bullying and the health issues Miss Fallowfield alluded to in her mitigation statement and subsequent communication with the NMC, although the panel has little evidence to support this.

The panel was aware that it could impose any of the following sanctions; take no further action, make a caution order for a period of one to five years, make a conditions of practice order for no more than three years, make a suspension order for a maximum of one year, or make a striking-off order.

The panel considered the potential sanctions in ascending order of restrictiveness.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel has already found that Miss Fallowfield's fitness to practise is impaired on the grounds of public interest as well as on public protection grounds. As such, the panel concluded that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate

where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Fallowfield's actions were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. In addition, having found Miss Fallowfield's fitness to practise is impaired on public protection grounds a caution order would provide no restriction on her practice. 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 Miss Fallowfield's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel considered that the misconduct identified in this case, whilst theoretically remediable, was not something which could be addressed through the imposition of conditions, especially in light of the panel's findings regarding Miss Fallowfield's lack of insight and remediation. The panel was therefore of the view that there are no practical or workable conditions that could be formulated, given the number and wide-ranging nature of the failings in this case. The panel also had no information before it as to whether Miss Fallowfield would be willing to engage with any conditions on her practice. Furthermore the panel concluded that the placing of conditions on Miss Fallowfield's registration would not adequately address the seriousness of this case and would not meet the public interest identified in this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

Miss Fallowfield was a senior nurse in a demanding leadership role and was responsible for managing a caseload of 14 vulnerable patients with mental health issues who were reliant on her for their physical and mental wellbeing and support. It was clear to the panel that Miss Fallowfield had demonstrated that she was able to do this role, but for some

reason over a protracted period of time beginning in 2013 she stopped fulfilling her role, which led to the failings and multiple charges the panel found proved in this case. Miss Fallowfield has briefly suggested a number of explanations for her failings, however none have been corroborated by any submissions from her or by any other evidence.

The SG states that a suspension order may be appropriate where some of the following factors are apparent:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel considered that the facts found proved demonstrated a pattern of behaviour over a period of some three years in which Miss Fallowfield neglected her responsibility to provide the basics of care to her allocated patients. The panel noted that Miss Fallowfield was responsible for a number of high risk, complex and vulnerable patients with a variety of mental health issues. In failing to conduct the appropriate reviews and risk assessments the panel considered that Miss Fallowfield had put her patients at a significant risk of harm. In particular, the panel considered that by not conducting the seven day follow up upon discharge from an inpatient facility Miss Fallowfield put two of her most vulnerable patients at an extremely high risk of harm, most notably these patients were at an increased risk of suicide. Furthermore, her failings in respect of medication administration and management resulted in patients not receiving appropriate medication and may also have resulted in them receiving too much medication.

The panel considered Miss Fallowfield's lack of insight into the potential risks to her patients from her failings and her lack of compassion around the sub-standard service she provided to be indicative of attitudinal issues. As such the panel considered Miss Fallowfield to be at a high risk of repeating this behaviour should her practice not be restricted.

The panel considered that the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse and in this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction to protect the public or address the public interest in this case.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that the findings in this case raised fundamental questions about Miss Fallowfield's professionalism. Miss Fallowfield's actions were extremely serious and had the potential to cause significant harm to her patients. She did not provide the basics of care and through her failings in record-keeping she hampered fellow professionals in their provision of care to these patients.

The panel determined that Miss Fallowfield's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Fallowfield's misconduct was serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. Further the panel has nothing before it to suggest that if Miss Fallowfield were to remain on the register that her practice would improve. Miss Fallowfield has been afforded many opportunities to engage with the NMC over the last four years and to provide evidence of insight and remediation or evidence to support the issues raised in her mitigation statement. She has not done so.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Miss Fallowfield's actions in putting patients at a serious risk of harm, breaching fundamental tenets of the profession and bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standards required of a registered nurse.

Accordingly the panel is satisfied that a striking off order is necessary on the grounds of both public protection and public interest.

The panel was mindful of the potential impact that such an order may have on Miss Fallowfield but taking full account of the important principle of proportionality, the panel was of the view that the interests of the public outweighed Miss Fallowfield's interests.

The panel, therefore, directs the registrar to strike Miss Fallowfield's name from the Register. She may not apply for restoration until five years after the date that this decision takes effect.

Interim order

As the striking-off 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 Miss Fallowfield's own

interest until the striking-off sanction takes effect. The panel accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Edwards. He submitted that an interim suspension order, for a period of 18 months, should be made to cover the 28 day appeal period. He submitted that this was appropriate given the panel's findings.

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 to not make such an order would be incompatible with the panel's earlier findings and with the substantive sanction that it has imposed. The panel first considered whether it was appropriate to impose an interim conditions of practice order, but considered that no workable conditions could be formulated as identified at the sanction stage.

Therefore the panel decided to impose an interim suspension order for the same reasons as it imposed the substantive order and, having accepted Mr Edward's submissions, to do so for a period of 18 months in light of the likely length of time that an appeal would take to be heard if one was lodged.

The effect of this order is that, if no appeal is lodged, the striking off order will come into effect 28 days after notice of the decision has been served on Miss Fallowfield and the

interim suspension order will lapse. If an appeal is lodged then the interim suspension order will continue until the appeal is determined.

The panel's decisions will be sent to Miss Fallowfield in writing.

That concludes this determination.