Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 02 December 2024 – Wednesday 11 December 2024

Virtual Hearing

Name of Registrant:	**Sarah Rowley**
NMC PIN	07F2900E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (10 October 2008)
Relevant Location:	Wales
Type of case:	Misconduct
Panel members:	Bryan Hume (Chair, Lay member) Vanessa Bailey (Registrant member) Paul Leighton (Lay member)
Legal Assessor:	John Moir
Hearings Coordinator:	Hazel Ahmet
Nursing and Midwifery Council:	Represented by Rowena Wisniewska, Case Presenter
Ms Rowley:	Not in attendance and not represented at the hearing
Facts proved:	Charges 1, 2, 3a, 3b, 8
Facts not proved:	Charges 4, 5, 6a, 6b, 6c, 6d, 6e, 6f, 7, 9, 10
Fitness to practise:	**Impaired**
Sanction:	**Suspension Order (6 months)**
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 Ms Rowley was not in attendance and that the Notice of Hearing letter had been sent to Ms Rowley's registered email address by secure email on 22 October 2024.

Ms Wisniewska, 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 accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing, including instructions on how to join and, amongst other things, information about Ms Rowley's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Rowley

The panel next considered whether it should proceed in the absence of Ms Rowley. It had regard to Rule 21 and heard the submissions of Ms Wisniewska who invited the panel to continue in the absence of Ms Rowley. She submitted that Ms Rowley had voluntarily absented herself, and that a further delay of this matter may inconvenience the witnesses in this case. Ms Wisniewska submitted that a further adjournment may not secure Ms Rowley's attendance at any further date, and that there is strong public interest in the expeditious disposal of this case.

Ms Wisniewska referred the panel to the documentation from Ms Rowley which included an email from Ms Rowley to the Hearings Coordinator on 02 December 2024, stating the following:

> *[PRIVATE]*

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'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Ms Rowley. In reaching this decision, the panel has considered the submissions of Ms Wisniewska, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties.

The panel took into consideration the fact that Ms Rowley had sent a further email in relation to an adjournment application:

> *'I'm happy for it [the hearing] to go ahead as wouldnt (sic) know if I could make the next hearing …'*

Consequently, the panel noted that:

- No application for an adjournment has been made by Ms Rowley;
- Ms Rowley has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;

- A number of witnesses have attended today to give live evidence, whilst others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) for those involved in clinical practice and the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Rowley in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC in person. Ms Rowley will also 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 Ms Rowley'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 to proceed in the absence of Ms Rowley. The panel will draw no adverse inference from Ms Rowley's absence in its findings of fact.

Details of charge

That you, a Registered Nurse, while Clinical Lead at The Oaks Care Home:

1. On an unknown date in June 2022, left your shift before another nurse arrived on duty;

2. Failed to arrange nursing cover for the night shift of 13-14 July 2022

3. On or about 14 July:

   a) Failed to administer lorazepam to Resident B

   b) Signed to confirm you had administered lorazepam to Resident B when you had not

4. In July and August 2022, failed to refer Resident A to a dietician and/or otherwise escalate Resident A's weight loss.

5. Failed to Refer Resident A to a Tissue Viability Nurse between 5 June 2022 and 7 August 2022

6. With regard to Resident A's tissue deterioration, while responsible for Resident' A's care, failed to:

   a) Show horizontal and vertical measurements in one or more wound photographs

   b) Complete a wound chart entry in relation to one or more sets of wound photographs

   c) Complete one or more entries in the description column of the wound chart accurately and/or adequately

   d) On one or more occasions, ensure that Resident A's dressing was changed three times a day and/or that refusals by Resident A to have their dressing changed were recorded.

   e) Following removal of Resident A's total bed, put in place any or an adequate repositioning schedule

7. Between December 2021 and August 2022, failed to refer one or more Residents other than Resident A to a dietician

8. On or about 10 June 2022, failed to record the administration of a transdermal patch to Resident C in the controlled drug book.

9. Between 30 May 2022 and 15 June 2022, failed to ensure that there was a care plan and/or risk assessment in place for a new Resident within 48 hours of their admission.

10. On one or more occasions required in a Resident's care plan that they receive 1500ml of fluid a day regardless of whether or not that volume was clinically justified.

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

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

At the outset of the hearing, Ms Rowley made a request that this case be held in private. On 02 December 2024, Ms Rowley submitted the following through email to the hearing's coordinator:

[PRIVATE]

The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Wisniewska indicated that she did not support this application for the hearing to be in private as the reason provided by Ms Rowley's is not inextricably linked to the details of this case.

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 noted that none of Ms Rowley's own private matters would be referred to during the course of this hearing and noted that there is no good reason for this case

to be heard in private. Therefore, the panel determined that it would reject the application made by Ms Rowley to hold this hearing in private.

Background

Ms Rowley was employed as a Registered Nurse at the Oaks care Home (the Home) from January 2020 and was promoted to the role of clinical lead in February 2022 until August 2022 when she was summarily dismissed from the Home.

Ms Rowley's case involves 10 alleged charges in respect of incidents that occurred during her employment at the Oaks Care Home. The incidents in question are serious alleged failures of a registered nurse and relate to the following: a failure to ensure referrals are made to a dietician and tissue visibility nurse, a failure to ensure that there was a nurse on duty on night shifts, creating a high risk to elderly residents. Further, a failure to administer Lorazepam to an elderly patient receiving end of life care, and alleged failures in respect to record keeping failures, dressing change failures, and the lack of care when ensuring that a resident had an adequate repositioning schedule.

Decision and reasons on application to amend Charge 6d

The panel heard an application made by Ms Wisniewska, on behalf of the NMC, to amend the wording of charge 6d.

The proposed amendment was to change the words *'three times a day'* within charge 6d to *'every third day'*. It was submitted by Ms Wisniewska that the proposed amendment would provide clarity and more accurately reflect the evidence.

> "That you, a registered nurse:
>
> *'6) With regard to Resident A's tissue deterioration, while responsible for Resident' A's care, failed to:*

*d) On one or more occasions, ensure that Resident A's dressing was changed ~~three times a day~~ **at least every third day** and/or that refusals by Resident A to have their dressing changed were recorded.'*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (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 Ms Rowley 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 change the wording of charge 6d in order to ensure clarity and accuracy.

Decision and reasons on application to admit written hearsay evidence

The panel heard an application made by Ms Wisniewska under Rule 31 to allow the hearsay written statement of Witness 3 into evidence. Witness 3 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she had stated that she was unaware of these proceedings and was not prepared. Witness 3 then further made clear that she was not willing to be a witness in this case and was not compelled to attend by the NMC.

In the preparation of this hearing, the NMC had indicated to Ms Rowley in the Case Management Form (CMF), that it was the NMC's intention for Witness 3 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 3, Ms Rowley made the decision not to attend this hearing. On this basis Ms Wisniewska advanced the argument that there was no lack of fairness to Ms Rowley in allowing Witness 3's written statement to go before the panel. She noted that the statement of Witness 3 is not the sole or decisive evidence in relation to the majority of the charges. Ms Wisniewska noted that there is other evidence available within witness statements and exhibits, however, did note that Charge 8 is likely to be mainly supported by this statement of Witness 3.

Ms Wisniewska submitted Ms Rowley has made some informal admissions but has not formally admitted or denied all or any of the charges put forward by the NMC; she has not sought to challenge the witness evidence to any great degree.

Ms Wisniewska submitted that there is nothing to suggest Witness 3 has fabricated any of her evidence. She further noted that the allegations against Ms Rowley are serious and will likely have an adverse impact on her career if found proved.

Consequently, Ms Wisniewska submitted that the evidence of Witness 3 is relevant, fair, and should be admitted and considered.

The panel gave the application in regard to Witness 3 serious consideration. The panel noted that Witness 3'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 signed by her.

The panel considered whether Ms Rowley would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 3 to allowing a piece of hearsay testimony into evidence.

The panel considered that as Ms Rowley had been provided with a copy of Witness 3's statement and that Ms Rowley had chosen voluntarily to absent herself from these proceedings. Further, Ms Rowley had made an informal admission to Charge 8, to which this hearsay evidence relates, during the Home's investigation. There is also public interest in the issues being explored fully which supported the admission of this hearsay evidence into these proceedings. The panel considered that the unfairness in this regard worked both ways, in that, the NMC would be deprived, as would the panel, if it were not to allow reliance upon the hearsay evidence of Witness 3, specifically in relation to Charge 8.

In these circumstances, the panel came to the view that it would be fair and relevant to accept the hearsay evidence of Witness 3 but would give what it deemed

appropriate weight once the panel had heard and evaluated all the evidence before it.

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 Ms Wisniewska on behalf of the NMC.

Ms Wisniewska submitted that on the balance of probabilities, each of the 10 charges can be found proved. She highlighted that Ms Rowley has made some informal admissions to some of the charges, as has already been explored within the witness evidence of Witness 1. Ms Wisniewska submitted that Ms Rowley was an experienced nurse who was aware of what best practice is considered to be, and what was required of her as a registered nurse. Ms Wisniewska submitted that Ms Rowley, was the clinical lead with an extra *'layer'* of expertise and responsibilities and she fell short of the standards expected of her in her role.

In relation to Charge 1, Ms Wisniewska submitted that the evidence of Witness 1 should be taken into consideration regarding the alleged incident in June 2022; Ms Rowley leaving her shift before another nurse had arrived on duty. Witness 1 stated in her evidence, that Ms Rowley had left the premises of the Home through the back door and had hidden the work rota's. Ms Rowley was *'required to conduct herself professionally and in accordance with NMC standards, and not unprofessionally, by leaving night shifts uncovered and hiding the rota'.*

Ms Wisniewska submitted therefore that the allegations in charge 1 can be found proved by way of the evidence of Witness 1.

In relation to Charge 2, Ms Wisniewska submitted that the witness evidence of both Witness 1 and Witness 2 are relevant. She noted that Witness 2 had made clear to Ms Rowley that she was not available to work on the shift she was allocated, but Ms Rowley did not remove her from the rota. Ms Wisniewska noted that there are WhatsApp message exchanges to show that Witness 2 had made this clear to Ms

Rowley. Witness 1 made clear in her evidence that Ms Rowley left the Home ‘knowing there was no nurse on shift’.

Ms Wisniewska therefore invited the panel to find charge 2 proved.

In relation to Charge 3, Ms Wisniewska noted that the panel may consider the evidence of Witness 2. She noted that, following Ms Rowley having left after her shift at the Home, Resident B’s daughter had asked when her father would be receiving his dose of Lorazepam, as he was very anxious about dying. Witness 2 then stated in her evidence, that she had checked the MAR chart and had seen a signature there, noting that Ms Rowley had provided Resident B with Lorazepam at 8am. However, Witness 2 noted that when she checked the quantity of the medication and noted that there was an open box of 28 tablets; it was clear that there had been no administration of Lorazepam to Resident B. The family stated that there was no possibility that the medication had already been administered, as they were with him constantly, and did not witness this. Due to this, Witness 2 submitted that Resident B’s family were very upset and wanted to escalate this situation further. Witness 2 submitted that Ms Rowley had not made any clear comments relating to the administering of this medication, or lack therefore, but left promptly from the back door of the Home due to a disagreement with her manager.

Consequently, given the evidence provided by Witness 2, Ms Wisniewska invited the panel to find this charge found proved.

In relation to Charge 4, Ms Wisniewska submitted that the panel should take into account the evidence of Witness 1. In her written statement, Witness 1 had stated *‘as well as their [Resident A] weight loss not being addressed, there had been no referral of Resident A to the TVN’.* Witness 1 gave further oral evidence that all of the residents were weighed monthly, and a report was generated; if a resident had lost a substantial amount of weight, it would and should have been recorded. Ms Wisniewska noted that Witness 1 made clear that Resident A should have been referred to a dietician in July 2022 at the latest, and that this fell within the remit of Ms Rowley’s responsibility.

Consequently, in considering Witness 1's evidence in relation to Ms Rowley's failure to escalate such an issue, Ms Wisniewska submitted that the panel should find Charge 4 found proved.

In relation to Charge 5, Ms Wisniewska submitted that the panel should consider the evidence of Witness 4, who was the individual to handle referrals for the Home. Witness 4 had stated that there was a marked deterioration between 21 July and 26 July 2022. Ms Wisniewska submitted that Witness 4 made clear, that the prudent point of which to make a referral to the tissue viability nurse, would be as soon as deterioration was noticed. Witness 4 submitted that the wound was not reported and has spread across both buttocks of the resident, and that there was presence of necrotic tissue; this implied an involvement of pressure to this wound. Witness 4 said that the entries made in the daily records were very brief and said that wound care had been seen to, but rarely stated that the resident had been repositioned or that the skin had been inspected. Therefore, Ms Wisniewska highlighted through Witness 4's evidence, that no referral was made by Ms Rowley until there was serious deterioration of this resident's wound, and an unstageable pressure ulcer had occurred.

Ms Wisniewska submitted that the panel should find Charge 5 found proved.

In relation to Charge 6 and all sub charges which fall under this charge, Ms Wisniewska submitted that the evidence of Witness 1 must be considered.

Specifically in relation to Charge 6a and 6b, Ms Wisniewska noted that Witness 1 had said that Ms Rowley's quality on wound documentation was poor, and that she was asked to include measurements of wounds on multiple occasions, particularly for Resident A, but failed to do so.

In relation to Charge 6c, Ms Wisniewska submitted that the descriptions on the wound chart appear not to be detailed, adequate or accurate. She further noted that the descriptions can be deemed as sparce, and once again, as Witness 1 highlighted, measurements are missing.

In relation to Charge 6d, Ms Wisniewska submitted that there is no record of frequency of dressing changes made by Ms Rowley, nor is there a record of dressing changes being carried out at least every third day; there is also a failure to complete the most recent treatment column. She noted that the chart has large sections missing, and Witness 1 made clear within her oral evidence that it was an important step to record the refusal of a resident, if they did not wish to have a dressing changed.

In relation to Charge 6e, Ms Wisniewska submitted that Ms Rowley removed the total bed because she believed it was not *'doing any good'*, as Witness 1 stated. However, it was submitted that she then failed to put in any adequate repositioning regime, with no regular repositioning occurring, or electronic *'must tool'* [Malnutrition Universal Screening Tool] actions being implemented, such as charting.

Ms Wisniewska therefore invited the panel to find Charge 6 and all of the sub charges, found proved.

In relation to Charge 7, Ms Wisniewska stated that the panel should note that there were a number of residents who required dietician referrals during the period stated within this charge. She noted that Witness 1 in her written statement makes clear, that after Ms Rowley had left her role at the Home, Witness 1 conducted a review of resident weights and found that many of them had not been referred to their GP or their dieticians whilst under the care of Ms Rowley. She noted that no referrals were made as there were no resident records; staff emails were also reviewed by Witness 1, and no sent items existed which evidenced referrals to a dietician.

Ms Wisniewska therefore submitted that Charge 7 should be found proved.

In relation to Charge 8, Ms Wisniewska submitted that this charge is primarily covered by the hearsay evidence of Witness 3, which was admitted before the panel. This charge is further supported by Ms Rowley's own informal admission. Ms Rowley had made an admission that she had administered the transdermal patch to Resident C, however failed to enter it into the controlled drugs book. Ms Rowley

stated that she was aware of her error and had reflected on her practice, and that the manager at the time had advised her on her error.

The admission by Ms Rowley is corroborated and supported by the hearsay statement of Witness 3; within her statement she had attached an exhibit labelled *Exhibit NO1: Safeguarding referral relating to Resident C.*

Ms Wisniewska therefore invited the panel to find Charge 8 proved.

In relation to Charge 9, Ms Wisniewska submitted that Witness 1 was asked about the rationale / time period of 48 hours whereby a nurse must ensure that there is a care plan and / or risk assessment in place for a new resident. Witness 1 submitted that no risk assessments were set in place, and that the care plan section on the relevant document was blank for the new resident. Ms Wisniewska submitted that, for staff to work without any information is not only dangerous for them, but also for the resident themselves.

She therefore invited the panel to find Charge 9, proved.

Finally, in relation to Charge 10, Ms Wisniewska submitted that, when checking care plans, Witness 1 found that all residents were care planned to receive 1500ml of fluid a day and noted that this *'one size fits all'* approach taken by Ms Rowley created risks to patient which could have seriously affected their health. Witness 1 gave an example of Resident F, who was care planned to receive 1500ml of fluid a day, when in actuality, they should have been receiving 1334ml instead. Witness 1 noted that there are fluid guidelines on each floor of the Home, and that the members on the other two floors of the Home were following this protocol correctly. Therefore, Ms Wisniewska submitted that it is clear from the evidence of Witness 1, that Ms Rowley did not consider the recommended fluid intake by both weight and height, as was expected of her.

Ms Wisniewska invited the panel to find Charge 10, proved.
Consequently, the NMC invited the panel to find all of the allegations proven.

The panel has drawn no adverse inference from the non-attendance of Ms Rowley.

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

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

Witness 1:	General Manager of the Care Oaks Home.
Witness 2:	Bank Nurse at the Home at the time.
Witness 4:	Tissue Visibility Nurse at Powys Teaching Health board.

The panel had sight of the hearsay written evidence of the following witness:

Witness 3:	Designated Lead Manager for Safeguarding Adults at Powys County Council.

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

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

Charge 1

'That you, a Registered Nurse, while Clinical Lead at The Oaks Care Home: On an unknown date in June 2022, left your shift before another nurse arrived on duty'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, in which she submitted *'[…] when Ms Rowley left, they left with no other nurse in the building or on the rota for the following shift'.* The panel noted that Witness 1 gave a substantial amount of detail in relation to this charge. The panel therefore determined that it accepted the evidence of Witness 1.

Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 2

> *'Failed to arrange nursing cover for the night shift of 13-14 July 2022'*

This charge is found proved.

The panel took into account Ms Rowley having been questioned about the WhatsApp messages during the Home's investigation, in which it can be confirmed that she was aware that there was not going to be a nurse on shift when she had left the premises of the Home. Ms Rowley was asked*:*

> *'In relation to the rota and leaving of shifts. I need to make you aware that I have seen the texts from the other party saying she couldn't do them shifts. Can you confirm that you knew there wasn't going to be a nurse when you left'*.

Ms Rowley responded:

> *'Yes, I did'.*

Further, the panel considered the oral evidence of Witness 2, in which she stated that Ms Rowley had called her and apologised for having left the shift, knowing there was no other nurse present.

On the balance of probabilities, the panel found this charge proved.

Charge 3a

'Failed to administer lorazepam to Resident B'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2,

The panel further took into account the admission made by Ms Rowley that she did not administer Lorazepam to Resident B, she stated:

'I then noticed he was wrote up for PRN lorazepam, went back into This room and due to Him being very sleepy and rested I did not administer the lorazepam, but I signed it instead of using the code to Say not administered'

The panel also considered the statement of Witness 2, in which she detailed her discussion with Resident B's family, and their discontent in lorazepam not having been administered to him. Witness 2 stated the following:

'I told Resident B's daughter that the records indicated that lorazepam had been given, and they responded that Resident B had not received any lorazepam that morning. I knew I would be able to check this by checking stock of the medication, so I opened the medication box and found Resident B's lorazepam, which was in a new unopened box. This showed that it had not been administered in the morning, as Miss Rowley had recorded.'

Therefore, in taking into account the informal admission of Ms Rowley and the statement of Witness 2, on the balance of probabilities, the panel found this charge proved.

Charge 3b

'Signed to confirm you had administered lorazepam to Resident B when you had not'

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Witness 2, as stated above, whereby she witnessed Ms Rowley's signature on the MAR chart and had found that there was no medication administered.

It further took into account Ms Rowley's admission within the disciplinary meeting, in which she stated the following:

'I was due to administer this medication early in the day, but the family asked that I give it a bit later on. I had already signed it on the MAR Chart so should have corrected this when it was not dispensed.'

Consequently, the panel find this charge proved based on the evidence of Witness 2 and Ms Rowley's own admission.

Charge 4

'In July and August 2022, failed to refer Resident A to a dietician and/or otherwise escalate Resident A's weight loss'

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident A's weight history graph and considered the information presented between the period of July 2022 and August 2022. The panel determined that there is no evidence to show, that between July 2022 and August 2022, Resident A was at an abnormal weight. The panel noted that the details of his graph make clear that Resident A appeared to be at a stable weight within normal BMI, therefore, there was no clinical indication for a referral to a dietician, and therefore no specific failure on Ms Rowley's part, during the period of the months stated within this charge.

Charge 5

> *'Failed to Refer Resident A to a Tissue Viability Nurse between 5 June 2022 and 7 August 2022'*

This charge is found NOT proved.

In reaching this decision, the panel has had sight of clinical notes which show that a registered nurse in the Home documented on 5 June 2022 that they observed a pressure sore and classified this at Grade 3. However, this nurse did not make the necessary referrals as expected in this situation, nor do we have any indication that she discussed this with Ms Rowley as the clinical lead.

The panel considered the fact that Witness 4, who was a Tissue Viability Specialist, had noted this classification was incorrect. However, the panel did not have sight as to whether a conversation relating to this had occurred between Witness 4 and Ms Rowley as indicated in the clinical notes.

The panel did have knowledge however, that a doctor visited on 7 June 2024, and there was a further doctors visit whereby they communicated with a bank nurse on shift in relation to Resident A's wound and made a further referral on 15 June 2022.

Additionally, the panel considered Ms Rowley's response to the NMC in relation to the failure to refer Resident A to the TVN. She submitted that *'I went on leave for the 3 weeks and when I returned I found this wound to have increased In size and become necrotic, a referral had been sent while I was away, I cannot comment if the tissue viability nurse had been out but I sent another referral off and she visited while I was on shift, between then and my last day at Sandstone there was a dramatic improvement.'* The panel considered that Ms Rowley's response to the NMC was consistent with that of Witness 4. The panel further noted that Ms Rowley made a referral a few days after she had returned to work, which was 8 August 2022.

Further, the panel took into consideration the witness statement of Witness 4, whereby she stated the following: *'The Deputy was able to confirm that the lateral*

turning device had arrived on 26th July & been put in situ same day.' The panel noted that on this date, Ms Rowley was not on shift as she was on leave, and therefore, the deterioration which occurred, was the accountability of another individual.

The panel took into account the statement of Witness 4 whereby she made clear that the main deterioration occurred during the dates 21 July 2022 through to 26 July 2022. Consequently, the panel considered the fact that the majority of the deterioration of Resident A's wound, occurred whilst Ms Rowley was on leave.

The panel was concerned to note that on 26 July 2024 there is an alleged entry referencing another nurse appearing to be from Ms Rowley; however, the panel noted that within the rota, it makes clear that she was on leave from 15 July 2022, through to 31 July 2022.

Therefore, on the balance of probabilities, the panel found this charge NOT proved.

Charge 6a

> *'Show horizontal and vertical measurements in one or more wound photographs'*

This charge is found NOT proved

In reaching this decision, the panel took into account the fact that none of the photos of the wounds were taken with either horizontal or vertical measurements; these photos before the panel were taken by numerous, different members of staff.

The panel took into consideration the evidence of Witness 1, who stated that she had spoken to Ms Rowley on numerous occasions about taking horizontal/vertical tape measurements, however nothing was done during the taking of photos. However, the panel have no evidence or notes that these conversations had ever occurred.

The panel further noted that Witness 4 had stated the importance of writing measurements was good practice as sometimes images do not represent the accuracy. However, Witness 4 did make clear that this was not a requirement.

The panel determined that the NMC have failed to prove that Ms Rowley had a duty to take such measurements, as described in the charge.

Consequently, on the balance of probabilities, this charge is found NOT proved.

Charge 6b and Charge 6c

> *'Complete a wound chart entry in relation to one or more sets of wound photographs'*
>
> *'Complete one or more entries in the description column of the wound chart accurately and/or adequately'*

These charges are found NOT proved.

The panel determined that it would consider charges 6b and 6c together.

In reaching this decision, the panel took into account the various photos and wound charts, noting that there were no entries on the chart or images which were attributed to any nurse, or identifiable as having been written by any nurse.

Therefore, the panel determined that it cannot specifically conclude that Ms Rowley failed to make such entries.

Consequently, on the balance of probabilities, these two charges are found NOT proved.

Charge 6d

‘On one or more occasions, ensure that Resident A’s dressing was changed at least every third day and/or that refusals by Resident A to have their dressing changed were recorded.’

This charge is found NOT proved.

The panel determined that it has not been supplied with sufficient notes in relation to this charge. It considered that such notes are not comprehensive enough to determine an outcome as they do not include all relevant dates pertaining to Charge 6d.

Consequently, the panel determined that this charge is found NOT proved.

Charge 6e

‘Following removal of Resident A’s total bed, put in place any or an adequate repositioning schedule’

This charge is found NOT proved.

The panel noted that Resident A’s total bed was not removed until October 2022, according to the report made to the coroner. It was stated *‘the mattress […] was removed on advice from the TVN [Witness 4] on 22/10/22 and the turning regime remained in place.’*

The panel determined that, as Ms Rowley was not practicing at this Home by this date, she could not have any responsibility for the failure mentioned in this charge.

Consequently, this charge is found NOT proved.

Charge 7

‘Between December 2021 and August 2022, failed to refer one or more Residents other than Resident A to a dietician’

This charge is found NOT proved.

In reaching this decision, the panel took into account the fact that the only identifiable resident on the Resident Observation Chart for weight, is Resident F. Further, Witness 1 within her oral evidence noted that she held doubts relating to the accuracy and validity of some of the entries within this chart.

Further, the panel noted from JR-39, Resident F's *'must tool'*, that the initial entry on which the weight loss was calculated is noted to have been incorrect. Accordingly, the weight loss subsequently flagged with an error.

Therefore, panel have insufficient evidence to prove this charge, as there is nothing to suggest that Resident F specifically, was required to be referred to a dietician due to a change in their weight.

Consequently, on the balance of probabilities, this charge is found NOT proved.

Charge 8

> *'On or about 10 June 2022, failed to record the administration of a transdermal patch to Resident C in the controlled drug book.'*

This charge is found proved.

In reaching this decision, the panel took into account Ms Rowley's own informal admission to this charge during her responses to the NMC in the referral stage. When asked the following:

> *'Controlled Drug errors have been picked up and have been referred to the safeguarding team on […] occasions, you have been the nurse on duty on […] occasions that the errors occurred. Can you explain the errors?'*.

Ms Rowley responded the following:

'The first was a patch for Resident C I went to put it on him and was called away to another resident, so I forgot to add this to the book. The other nurses then carried on the count without checking for the discrepancy.'

The panel also took into consideration the statement of Witness 3, in which she reflects on the referral that was made by Ms Rowley, mirroring a similar explanation.

Consequently, on the balance of probabilities, this charge is found proved.

Charge 9

'Between 30 May 2022 and 15 June 2022, failed to ensure that there was a care plan and/or risk assessment in place for a new Resident within 48 hours of their admission.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1, in which she stated that she was *'horrified'* to find that the risk assessment had not been completed for the new resident who had joined the Home.

Ms Rowley made a partial admission to this, in that she admitted that she was unable to complete the risk assessment as there were two admissions in one day and she had run out of time. She had claimed that she had completed the risk assessment for the first resident, however, was unable to fully complete a risk assessment for the second resident. Ms Rowley stated the following, in her response to the NMC:

'We had 2 admissions In one day and it was impossible to do risk Assessments and care plans for both admissions within 24 hours, Again I asked for help, but could not rely upon agency staff to help me, so one was completed and the other was not competed fully only basic information was inputted when the care plan was audited by the home manager'

Witness 1 in her oral response to the NMC, stated that there is no possibility that two admissions could have occurred within one day.

The panel determined that it was not given details or evidence of a care plan or risk assessment for the unidentified resident in relation to this charge. The panel noted further that it does not have before it any date of admission of this resident, and no indication that Ms Rowley was on duty on this alleged date.

Consequently, due to insufficient evidence, and on the balance of probabilities, this charge is found NOT proved.

Charge 10

> *'On one or more occasions required in a Resident's care plan that they receive1500ml of fluid a day regardless of whether or not that volume was clinically justified.'*

This charge is found NOT proved.

The panel determined that it has before it no evidence as to which exact resident this charge is in relation to. It noted that it has before it a Fluid Watch and Cap, in relation to Resident F. This relates to the target of 1500ml, but no such document was provided in relation to any of the other residents. No explanation is provided for any other reason which might require an increase of fluid intake, such as high temperature. The panel had no information before it to confirm that this charge relates specifically to Resident F. The panel was further unaware of exactly how many millilitres of fluid should have been administered to each resident in the Home, as opposed to the 1500ml which was assigned to them.

The panel took into consideration the statement of Witness 1, and noted her statement that there is a sheet which specifies what a patient should receive according to their weight on each floor of the Home. The panel indicated that overall, there is no clinical indication or reliable observation to find this charge proved.

Consequently, on the balance of probabilities, this charge is found NOT proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Rowley'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 ability to practise kindly, safely and professionally.

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, Ms Rowley'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.'*

Ms Wisniewska 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: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code)

Ms Wisniewska identified the specific, relevant standards where Ms Rowley's actions amounted to misconduct.

Ms Wisniewska submitted that the residents involved within this case were elderly and vulnerable. She submitted that Ms Rowley failed to work effectively, cooperatively, or maintain effective communication with her colleagues, keeping them informed of important information when sharing the care of individuals with them.

Ms Wisniewska submitted that Ms Rowley failed to share information to identify and reduce the potential harm which could have occurred in relation to the residents in her care. She further noted that Ms Rowley failed to safely administer the correct medication to a resident or deliver the fundamentals of care effectively, failing to be open and candid with all service users.

Ms Wisniewska submitted that Ms Rowley's actions, for the reasons set out above, amounted to actual harm and also a real risk of harm to the residents in her care.

Ms Wisniewska submitted that Ms Rowley's actions do amount to serious professional misconduct, which is a *'route to impairment'*.

Submissions on impairment

Ms Wisniewska 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).

Ms Wisniewska submitted that for all of the reasons set out within the misconduct section of this determination, Ms Rowley has presented a real risk of harm and a potential for repetition of such harm in the future. Ms Wisniewska submitted that Ms Rowley's past misconduct is an indication of her having placed the residents in her care in a position of unwarranted risk of harm.

Ms Wisniewska noted that Ms Rowley has not provided any level of reflection into her actions and the way in which these had an impact on the residents in her care. Further, Ms Rowley has not presented any level of remediation. Consequently, such a lack of information points to an ongoing risk to patients and therefore, a finding of current impairment.

Ms Wisniewska submitted that Ms Rowley failed to practice effectively, not taking active measures to ensure that patients were safe. Further, Ms Rowley failed to communicate clearly with her colleagues for the safety and wellness of the residents depending on her for their care and wellbeing. She submitted therefore, that as a result of such actions, and in considering the nature of Ms Rowley's actions in this case, a finding of impairment in this case is *'inescapable'*.

Ms Wisniewska therefore submitted that Ms Rowley is currently impaired by reason of her misconduct, her lack of insight and her lack of remediation.

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), and *General Medical Council v Cohen* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

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

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

> ***'1) Treat people as individuals and uphold their dignity***
>
> > *1.2) make sure you deliver the fundamentals of care effectively*
>
> ***2) Listen to people and respond to their preferences and concerns***

2.1) work in partnership with people to make sure you deliver care effectively

8) Work co-operatively

8.2) maintain effective communication with colleagues
8.3) keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.5) work with colleagues to preserve the safety of those receiving care
8.6) share information to identify and reduce risk

10) Keep clear and accurate records relevant to your practice

10.1) complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event
10.2) identify any risks or problems that have arisen, and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3) complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

14) Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1) act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
14.2) explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3) document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

20.1) keep to and uphold the standards and values set out in the Code
20.8) act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel found that Ms Rowley's actions in all of the charges found proved in this case, do 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, Ms Rowley's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

'The question that will help decide whether a professional's fitness to practise is impaired is:
"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"
If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not 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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel finds that patients were caused emotional harm, as were their family members, and the residents in Ms Rowley's care were also caused a real risk of

physical harm as a result of her misconduct. Ms Rowley's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Rowley has taken steps to strengthen her practice, and whether or not she has shown any insight into her failings.

Regarding insight, the panel considered that Ms Rowley has not provided any evidence of insight into her actions and the way in which these impacted the residents in her care, or their families.

Further, the panel took into account the fact that it had no evidence before it of Ms Rowley's current situation in relation to her work, and whether or not she has undergone any form of re-training in order to remediate her practice. The panel are unaware as to whether or not she has continued to work as a registered nurse, and/or in what capacity she currently is employed.

The panel is of the view that there is a risk of repetition based on Ms Rowley's lack of insight and lack of any evidence of 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 because a member of the public would be appalled if they were informed that a Home were left unattended, with no registered nurse on shift, with multiple residents who required safe and effective care. A well informed and reasonable

member of the public would expect a registered nurse facing charges which amount to such misconduct, to have their fitness to practice deemed impaired in some form.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months. The effect of this order is that the NMC register will show that Ms Rowley's registration has been suspended.

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

Submissions on sanction

Ms Wisniewska informed the panel that in the Notice of Hearing, the NMC had advised Ms Rowley that it would seek the imposition of a suspension if it found Ms Rowley's fitness to practise currently impaired.

Ms Wisniewska submitted that panel have found that Ms Rowley has not shown any insight or provided any evidence of remediation in the form of training. Ms Wisniewska submitted that Ms Rowley has also provided no information relating to her current employment situation and therefore, no evidence of her current capacity and whether or not she has remained within a nursing position during the interim period.

Ms Wisniewska submitted therefore, that given Ms Rowley's lack of demonstration of insight, training, remediation or remorse, there remains a risk of repetition. Ms Wisniewska reminded the panel that of their finding, that Ms Rowley's actions fall seriously short of the conduct and standards expected of a registered nurse.

Ms Wisniewska submitted that the following aggravating factors are engaged:

- Ms Rowley's failings were serious and covered a range of issues;
- Patients and their families suffered emotional harm;
- There was a real risk of physical harm;
- Ms Rowley has shown no insight or remediation;
- Ms Rowley had a significant level of responsibility in her role as clinical lead.
- Charges 1, 2, 3a and 3b are indicative of attitudinal problems which may not be easy to address.

Ms Wisniewska submitted that there are no mitigating factors in this case.

Ms Wisniewska submitted that no order, or a caution order, would not be appropriate in this case due to the findings the panel have made in relation to charges found proved, misconduct, and impairment.

Ms Wisniewska submitted that there are no workable, relevant or measurable conditions which could address Ms Rowley's misconduct. Therefore, she submitted that the appropriate sanction in this case would be a suspension order for 10 months.

Decision and reasons on sanction

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

The panel took into account the following aggravating factors:

- Ms Rowley's failings were serious and covered a range of issues;

- Patients and their families suffered emotional harm;
- There was a real risk of physical harm;
- Ms Rowley has shown no insight or remediation;
- Ms Rowley had a significant level of responsibility in her role as clinical lead.

The panel took into account the mitigating factors in this case:

- The Home which Ms Rowley was working in was a *'failing'* Home, as confirmed by Witness 1; the atmosphere was difficult to work in.
- Ms Rowley was placed in a management role, and the panel had not been provided any evidence of training or mentoring which she was provided to prepare her for this role.
- [PRIVATE]

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 decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Rowley's practice would not be appropriate in the circumstances. The SG 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 Ms Rowley's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Rowley'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 took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and its lack of information about Ms Rowley's current employment. Furthermore, the panel noted that the placing of conditions on Ms Rowley's registration would not adequately address the seriousness of this case and would not protect the public, given the fact that the panel has before it no evidence of retraining, improvement, or the remediation of her failures.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *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;*

- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

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

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

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

The panel noted the hardship such an order will inevitably cause Ms Rowley. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to maintain public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 6 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- A reflective piece provided in relation to how Ms Rowley's actions impacted patients and their family members under her care, and how she would face a similar situation in the future;
- Testimonials and evidence of what Ms Rowley has been doing in the interim period, showing evidence that she has acted responsibly in any role she has been working in;
- Evidence of medication management retraining including accurate documentation practises.

This will be confirmed to Ms Rowley in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She invited the panel to make an interim suspension order for a period of 18 months in order to cover any appeal period; she made this request based on both grounds of public protection and in the wider public interest.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to cover any appeal period.

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

That concludes this determination.