Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 13 May 2024 – Friday, 17 May 2024
Monday, 20 May 2024 – Friday, 24 May 2024
Tuesday, 22 October 2024 – Friday, 25 October 2024
Tuesday, 21 January 2025 – Wednesday, 22 January 2025

Virtual Hearing

Name of Registrant:	Karen Brown
NMC PIN	84K0737E
Part(s) of the register:	Nurses part of the register Sub part 1 RN3: Mental health nurse, level 1 (01 March 1992) Nurses part of the register Sub part 2 RN4: Mental health nurse, level 2 (19 February 1987)
Relevant Location:	North Tyneside
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Anne Murray (Registrant member) Jane Malcolm (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Eleanor Wills (13 May 2024 – 24 May 2024) Monsur Ali (22 October 2024 – 25 October 2024) Eleanor Wills (21 January 2025 – 22 January 2025)
Nursing and Midwifery Council:	Represented by Yusuf Segovia, Case Presenter
Mrs Karen Brown:	Present (13 May 2024, 21 May 2024) Not present (14 May 2024 – 17 May 2024, 20 May 2024, 22 May 2024 - 24 May 2024,

	22 October 2024 – 25 October 2025 and 21 January 2025 – 22 January 2025) Represented by Simon Holborn instructed by NMC Watch (13 May 2024 – 24 May 2024) Represented by Khaled Hussain-Dupre on behalf of Sequentus (22 October 2024 – 25 October 2024 and 21 January 2025 – 22 January 2025)
No case to answer:	Charge 13
Facts proved by admission:	Charges 3a, 3b, 4a, 10a, 14b, 15a, 15b, 15di, 15dii, 15e, 15g, 15h
Facts proved:	Charges 2b, 4c, 4d, 5, 6, 7, 9, 14a, 15f, 16
Facts not proved:	Charges 1a, 1b, 1c, 2a, 4b, 8, 10b, 11, 12, 15c
Fitness to practise:	Impaired, in relation to Charges 5, 7, 9, 14a, 14b and 15f
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice (18 months)**

At the opening of the case a request was made by Ms Watters from NMC Watch on your behalf, for a short delay to accommodate Mr Holborn who had to attend to another matter.

Mr Segovia on behalf of the Nursing and Midwifery Council (NMC) opposed this request.

The panel decided to grant the request for a short delay, in fairness to you, so that your representative, Mr Holborn may attend.

The panel was informed at the start of the hearing that you would not be in attendance whilst the NMC Witnesses gave their oral evidence.

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

At the outset of the hearing, Mr Holborn on your behalf made a request that this case be held partly in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Segovia indicated that he did not oppose the application to the extent that any reference to [PRIVATE] shall be in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised in order to protect your privacy.

Details of charge

That you, a registered mental health nurse:

1. In relation to Patient B, on one or more occasions prior to 6 April 2020 did not:
    a. Set clear boundaries. **[FOUND NOT PROVED]**
    b. Set specific times for appointments. **[FOUND NOT PROVED]**
    c. Support them to be more self-reliant. **[FOUND NOT PROVED]**

2. On a date on or around 28 January 2020:
    a. Overshared personal information with Patient C and/or their mother. **[FOUND NOT PROVED]**
    b. Did not send information relating to the completion of PIP assessment forms as promised. **[FOUND PROVED]**

3. In relation to Patient N, on one or more occasion:
    a. Picked up the patient's medication from the pharmacy and took it to the patient's home. **[PROVED BY ADMISSION]**
    b. Contacted the GP on their behalf. **[PROVED BY ADMISSION]**

4. Between 15 April and 30 June 2020:
    a. Had limited contact with Patient E. **[PROVED BY ADMISSION]**
    b. Did not fully record what had happened during your sessions with Patient F. **[FOUND NOT PROVED]**
    c. In relation to Patient H:
        i. Did not achieve contact with them. **[FOUND PROVED]**
        ii. Did not flag or raise a concern in relation to the lack of contact. **[FOUND PROVED]**
        iii. Did not try to assertively contact them. **[FOUND PROVED]**
    d. Had minimal contact with Patient L. **[FOUND PROVED]**

5. Between 27 December 2019 and 30 June 2020, on one or more occasion, in relation to Patient G did not record that plans had been followed through. **[FOUND PROVED]**

6. Between 29 April and 30 June 2020 had minimal contact with Patient I. **[FOUND PROVED]**

7. Despite being allocated Patient J on or around 29 November 2019 did not ensure that their formulation was added to their record prior to 26 June 2020. **[FOUND PROVED]**

8. Between 5 December 2019 and 30 June 2020 did not record evidence of any assessment or intervention around Patient K's mental health needs. **[FOUND NOT PROVED]**

9. Between 1 April and 30 June 2020 had minimal contact with Patient M and/or did not record that plans had been carried through. **[FOUND PROVED]**

10. Between 3 December 2019 and 30 June 2020, in relation to Patient O:

    a. On one or more occasion assisted them with a housing issue. **[PROVED BY ADMISSION]**

    b. Recorded minimal information about assessment of their mental health and/or their formulation and/or treatment plan. **[FOUND NOT PROVED]**

11. In relation to Patient P, stated in supervision that the main focus would be on assisting them to locate their brother's burial/cremation details. **[FOUND NOT PROVED]**

12. Between 6 January and 18 June 2020, in relation to Patient R, did not properly consider the treatment plan and/or record that it was being followed through. **[FOUND NOT PROVED]**

13.On a date on or around 20 April 2020 were aggressive in your communications with the midwifery team. **[NO CASE TO ANSWER]**

14.On 28 May 2020:

a. Despite being asked to no longer work with Patient D, left a voicemail on their phone and/or attended their home address. **[FOUND PROVED]**

b. Having been informed of a concern relating to Patient D's dog did not inform your manager and/or make an incident report. **[PROVED BY ADMISSION]**

15.In relation to Patient A:

a. On one or more occasions took them to play group. **[PROVED BY ADMISSION]**

b. On one or more occasions took them shopping and/or did their shopping for them. **[PROVED BY ADMISSION]**

c. Did not arrange for carer help and/or for a social care package to be put in place. **[FOUND NOT PROVED]**

d. On 30 December 2019:

i. Attended Patient A's address when they were locked out as opposed to helping them problem solve and/or calm them down over the phone. **[PROVED BY ADMISSION]**

ii. Revisited Patient A later in the afternoon. **[PROVED BY ADMISSION]**

e. Agreed to be their birthing partner and/or attended the birth of their child. **[PROVED BY ADMISSION]**

f. Did not record any conversations with Patient A and/or social services about being the birthing partner of A. **[FOUND PROVED]**

g. On one or more occasion looked after their child/children at your house. **[PROVED BY ADMISSION]**

h. Did not provide a proper handover to Colleague 1 (CB). **[PROVED BY ADMISSION]**

16.Your actions at charges 1 and/or 2 and/or 3 and/or 15 breached professional boundaries. **[FOUND PROVED]**

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

Background

The charges arose whilst you were employed as an agency mental health nurse by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (the Trust) as a Community Practitioner Care Coordinator within the North Tyneside East Community Treatment Team (CTT) from November 2019 until June 2020. During this time several concerns relating to your record keeping, relationships and communication with various patients and others, arose. It is alleged that your conduct in relation to some of these concerns breached professional boundaries.

Submissions on application of no case to answer

At the conclusion of the NMC case, the panel considered an application from Mr Holborn that there is no case to answer in respect of all of the charges. This application was made under Rule 24(7) and Rule 24(8).

In relation to this application, Mr Holborn provided written submissions to the panel, which raised specific issues in relation to the evidence presented for each charge. In summary he submitted that there is a lack of sufficient evidence to support a finding that you have breached 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) or professional boundaries. He submitted that the evidence presented lacks reliability, credibility and is of little probative value. He submitted that the witness evidence included opinions and was not consistent with the documentary evidence presented. Further he submitted that three of the witnesses are not registered nurses and therefore cannot give evidence of breaches of the Code or any breach of professional boundaries. Further he submitted that the charges lack clarity and specificity, rendering them inadequate for the purpose of fair adjudication.

Mr Holborn submitted that the evidence presented is therefore insufficient to support a finding that any of the charges could be found proved or in any event, to support a finding of impairment. In these circumstances, it was submitted that the charges should not be allowed to remain before the panel.

Mr Segovia submitted that in respect of Mr Holborn's application under Rule 24(7) that the NMC does not set out breaches of the Code at the factual stage, it is a matter to address when determining if the charges found proved amount to misconduct. He submitted that the fact that three of the witnesses are not registered nurses by no means undermines the evidence they have given, in that they are registered professionals who worked with or in the CTT. Mr Segovia submitted that the charges are specific and clear.

Mr Segovia provided submissions in turn on each charge. In summary he submitted that there is clear and consistent evidence provided in respect of all the charges in that patient records for patients A-R, are provided for the relevant time periods. He submitted that the information contained within the records was corroborated by Witness 1's oral evidence, written statement signed and dated 29 October 2021 and supplementary statement signed and dated 27 March 2023, in respect of all charges.

Mr Segovia submitted that in relation to charge 13, Witness 1 confirmed in her oral evidence the note of a complaint from the head of Midwifery about an issue having arisen regarding your communication, signed and dated by Witness 1 on 29 October 2021. Mr Segovia submitted that it is clear from other documentary evidence presented that communication did occur between yourself and the Midwifery team. Mr Segovia conceded that Witness 1 could not attest to the fact that the communication was of an aggressive nature. However, he submitted that the note of the complaint from the Head of Midwifery, signed and dated by Witness 1 on 29 October 2021, albeit hearsay evidence, is still sufficient to support charge 13. He submitted that the note of the complaint clearly states that the complaint was regarding your '*aggressive'* and '*hostile'* manner of communication

with members of the Midwifery service. He accepted however that there was no evidence that went to the detail of any aggressiveness on your part.

Mr Segovia submitted regarding charge 15 in addition to Patient A's records and Witness 1's oral evidence, written statement and supplementary statement there was clear and consistent corroborating evidence provided within your supervision records and Witnesses 2,3 and 4 in their written statements and oral evidence.

Mr Segovia submitted in relation to charge 16, that the overall question of whether you have breached professional boundaries is a question of judgment to be exercised by the panel at the stage of determining whether the charges found proved amount to misconduct. However, the panel at this stage needs to determine if there is evidence for a set of underlying facts which may raise an issue around professional boundaries to be considered. He submitted that the documentary evidence and oral and written evidence of the witnesses is sufficient to support this charge.

Mr Segovia submitted that there is sufficient evidence to support all the charges and therefore there is a case to answer and the application under Rule 24(7) should be refused.

Mr Segovia submitted that in respect of Mr Holborn's application under Rule 24(8), the charges are of a serious nature which directly relate to your practice as a mental health nurse, in that you did not provide appropriate care for a number of patients and went onto engage with former patients. Mr Segovia therefore submitted that sufficient evidence has been presented to support a finding of impairment.

Decisions and reasons on application of no case to answer

The panel took account of the submissions made and heard and accepted the advice of the legal assessor, which included reference to the cases of *R v Galbraith* [1981] 2 All ER

1060, *R v Shippey* [1988] Crim LR 767 and *Solicitors Regulation Authority v Sheikh* [2020] EWHC 3062.

Rule 24(7) of the Rules states:

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

Rule 24(8) of the Rules states:

> *'24 (8) Where an allegation is of a kind referred to in article 22(1)(a) of the Order, the Committee may decide*
>
> *(i) either upon the application of the registrant, or*
> *(ii) of its own volition,*
>
> *to hear submissions from the parties as to whether sufficient evidence has been presented to support a finding of impairment and shall make a determination as to whether the registrant has a case to answer as to her alleged impairment.'*

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel considered firstly whether sufficient evidence had been presented, such that it could find the facts proved and secondly whether sufficient evidence has been presented to support a finding of impairment.

The panel referred to the NMC guidance on *'Evidence'* reference *'NMA-6'* last updated 1 July 2022. The panel has specific regard to the section titled '*No case to answer'.*

The panel first considered the application made under Rule 24(7) of the Rules, and whether there was a case to answer on the facts in respect of each of the charges. In doing so, the panel made the following general observations. The panel noted that it is not its role, at this stage, to determine the *'weight'* any piece of evidence shall be given, but to look at the evidence presented to it so far and determine whether it is of a tenuous character either due to inherent weakness or vagueness, or because it is so inconsistent with other evidence. The panel had regard to the evidence from the NMC's witnesses and determined that at this stage it did not consider that the witnesses were so unreliable or discreditable so as to lead to the conclusion that the evidence they provided was of such a tenuous character that even taken at its highest, a properly directed panel could not find the charges proved.

The panel made the following conclusions in relation to each charge.

Charge 1

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 1 proved, and therefore there was a case for you to answer.

This was because the panel had regard to the evidence provided to it in Patient B's electronic patient record (RiO) notes from 21 November 2019 to 6 April 2020.The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement. Further the panel had sight of a note of a concern from Patient B recorded by Witness 1, dated 6 April 2020.

Charge 2

The panel determined that there was sufficient clear and consistent evidence presented to it, at this time, upon which a reasonable tribunal could find charge 2 proved, and therefore there was a case for you to answer.

This was because the panel had regard to the Witness 1's response, dated 14 February 2020, to a complaint from Patient C's mother received on 28 January 2020. The panel noted Patient C's RiO notes from 14 January 2020 to 21 January 2020, Witness 1's oral evidence, written statement, and supplementary statement.

Charge 3

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 3 proved, and therefore there was a case for you to answer.

This was because the panel had regard to the evidence provided to it in Patient N's RiO notes from 8 April 2020 to 30 June 2020 and noted the entries you made regarding the medication and the contact with the GP. The panel noted Witness 1's account provided to it in her oral evidence, written statement and supplementary statement.

Charge 4a

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 4a proved, and therefore there was a case for you to answer.

This was because the panel noted that in Witness 1's caseload update dated 11 June 2020 and Witness 1's review of the case records at the time that you left the CTT, that it is only recorded that on two occasions you phoned Patient E. The panel noted that it does

not at this stage have to determine whether or not that constitutes *'limited'* contact. The panel took into consideration Patient E's RiO notes from 15 April 2020 to 30 June 2020. The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 4b

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 4b proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient F's RiO notes from 15 April 2020 to 24 June 2020, and noted it appeared you did not record your sessions with Patient F. The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 4c

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 4c proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient H's RiO notes from 15 April 2020 to 30 June 2020 and noted the record of any contact with Patient H. The panel took into consideration the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 4d

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 4d proved, and therefore there was a case for you to answer.

This was because the panel took into consideration Patient L's RiO notes from 15 April 2020 to 30 June 2020, and noted the record of any contact with Patient L. The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 5

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 5 proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient G's RiO notes from 27 December 2019 to 17 June 2020 and noted the record of any contact and follow up plans. The panel noted the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 6

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 6 proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient I's RiO notes from 29 April 2020 to 30 June 2020 and noted the record of any contact with Patient I. The panel took into account

the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 7

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 7 proved, and therefore there was a case for you to answer.

This was because the panel took into account Patient J RiO notes from 29 November 2019 to 26 June 2020, and noted the record of formulation for Patient J. The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 8

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 8 proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient K's RiO notes from 15 December 2019 to 26 June 2020 and noted the record of any assessment of mental health needs. The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 9

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 9 proved, and therefore there was a case for you to answer.

This was because the panel took into account Patient M's RiO notes from 1 May 2020 to 30 June 2020 and noted the records of any contact and treatment plans. The panel took into consideration the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 10

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 10 proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient O's RiO notes from 3 December 2019 to 30 June 2020, and noted the records of housing issues, assessments of mental health needs, formulations and treatment plans. The panel took into consideration the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 11

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 11 proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient P's RiO notes from 28 April 2020 to 30 June 2020 and noted the entries in the records relating to Patient P's brother's burial/ cremation details. The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records.

Charge 12

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 12 proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient R's RiO notes from 6 January 2020 to 18 June 2020 and noted the record of any treatment plan and any subsequent actions. The panel took into consideration the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement.

Charge 13

The panel determined that there was NOT sufficient evidence presented to it, upon which a reasonable tribunal could find charge 13 proved, and therefore there was not a case for you to answer in relation to charge 13.

This was because the panel had regard to the complaint from the Head of Midwifery to Witness 1 signed and dated by Witness 1 on 29 October 2021, which appeared to raise a concern regarding your aggressive communication. The panel noted that it has not heard any evidence from members of the Midwifery team nor its management. The panel took into consideration the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement. Witness 1 stated that there had been communication between you and the Midwifery staff, but she could not provide any information on the specific words, tone or language used. The panel took into consideration of Patient Q's RiO notes from 16 April 2020 to 27 April 2020, and the entries relating to communication between you and the Midwifery team. The panel determined that the evidence provided was of a tenuous character as there was no first-hand evidence provided by the NMC that you were aggressive in your communication. The panel concluded that even if the evidence were taken as its highest, a properly directed panel could not find charge 13 proved.

Charge 14

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 14 proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient D's RiO notes from 3 December 2019 to 1 June 2020, and noted the dates when you were working with Patient D. The panel took into account Patient D's records, in relation to the alleged incident. Further the panel noted Witness 1's notes regarding a complaint about you from Patient D. The panel took into consideration the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement. Further the panel took into account the email from you to Witness 1 regarding Patient D dated 4 June 2020.

Charge 15a, 15b and 15c

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 15a, 15b and 15c proved, and therefore there was a case for you to answer.

This was because the panel took into account Patient A's RiO notes from 28 November 2019 to 30 June 2020 relating to your activity with Patient A. The panel had regard to Witness 1's oral evidence, written statement and supplementary statement. The panel also took into account the witness evidence and oral evidence of Witnesses 2, 3 and 4 regarding your interaction with Patient A.

Charge 15d

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 15d proved, and therefore there was a case for you to answer.

This was because the panel took into account Patient A's RiO notes from 28 November 2019 to 30 June 2020 and noted the record of your attendance at Patient A's home on 30 December 2019. The panel also took into consideration Witness 4's oral evidence and written statement dated 25 October 2021. The panel noted Witness 1's account given in her oral evidence.

Charge 15e and 15f

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 15e and 15f proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient A's RiO notes from 28 November 2019 to 30 June 2020 and noted the entries on Patient A's record in relation to her birthing arrangements. The panel noted the oral and written evidence provided by, Witnesses 1, 2 and 3 in relation to charge 15e and Witnesses 1, 2, 3 and 4 in relation to charge 15f.

Charge 15g and 15h

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 15g and 15h proved, and therefore there was a case for you to answer.

This was because the panel had regard to Patient A's RiO notes from 5 August 2020 to 21 August 2020 and noted the record of your interaction with Patient A and her children. The panel took into account Witness 3's oral evidence and written statement signed and dated 3 December 2023 and noted her evidence both in relation to your interaction with Patient A and any handover given to Witness 3 by you.

Charge 16

The panel determined that there was sufficient evidence presented to it, at this time, upon which a reasonable tribunal could find charge 16 proved, and therefore there was a case for you to answer.

This was because whilst the panel has heard no evidence supporting that your actions at charges 1, 2 and 3 breached professional boundaries at this time, indeed Witness 1 stated that in her opinion charges 1, 2 and 3 would not be in breach of professional boundaries. The panel however noted that there is sufficient evidence presented to it at this time, that a reasonable tribunal could find that your actions at charge 15 may have breached professional boundaries. The panel took into account the evidence of Witness 4 provided in her oral evidence and written statement and noted that it in relation to aspects of charge 15 you may have breached professional boundaries. Therefore, the panel determined due to the nature of the wording of the charge in that it could be found proved in relation to *'your actions at charges 1 and/or 2 and/or 3 and/or 15…',* that there is sufficient evidence at this time to find that there is a case to answer in relation to charge 16.

The panel next considered the application under Rule 24(8) of the Rules. The panel in light of all the oral, written and documentary evidence before it determined that sufficient evidence has been presented for there to be a case to answer as to your alleged impairment.

Decision and reasons on facts

During the course of your evidence, you informed the panel that you made admissions to charges 3a, 3b, 4a, 10a, 14b, 15a, 15b, 15di, 15dii, 15e, 15g and 15h.

In accordance with Rule 24(5) of the Rules, the chair therefore announced charges 3a, 3b, 4a, 10a, 14b, 15a, 15b, 15di, 15dii, 15e, 15g and 15 h proved, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Segovia on behalf of the NMC and by Mr Holborn on your behalf.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if the 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: Employed by the Trust as Clinical lead for CTT and acting Line Manager for you, at the relevant time.

- Witness 2: Safeguarding and Public Protection Practitioner and County lead for North Tyneside and Northumberland, at the relevant time.

- Witness 3: Employed by the Trust as Community Practitioner Care Coordinator in the CTT, at the relevant time.

- Witness 4: Employed by the Personality Disorder Hub Team at the Trust as a Consultant Clinical Psychologist, at the relevant time.

The panel also heard evidence from you under affirmation.

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

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

Charge 1

> "That you, a registered mental health nurse, in relation to Patient B, on one or more occasions prior to 6 April 2020 did not:
>
> a. Set clear boundaries.
> b. Set specific times for appointments.
> c. Support them to be more self-reliant."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5 of Witness 1's written statement in which she stated:

> '*Patient B wanted to switch care coordinators as he felt that he was too close to her [Mrs Brown]. He felt that there were inconsistent boundaries.'*
>
> *'I also noted that it was important to set specific times for appointments and set clear boundaries. Karen struggled to work in this way…'*

'This was initially Karen wanting to be really helpful to the patient and being very involved instead of supporting him in being more self-reliant.'

The panel took into consideration your oral evidence, written statement dated 20 May 2024 and documentary evidence provided. The panel accepted that you disputed these allegations and stated that *'you did everything right'* and that *'Patient B was very complex in his presentation'*. Further that you stated, *'Patients request change of care coordinators regularly'* and *'he [Patient B] regularly pushed away the people who were trying to help him'.*

The panel had regard to the note of the concern raised by Patient B, it was mindful that it was a second-hand account. The panel took into consideration that this note did not state that you did not set clear boundaries, specific times for appointments or did not support Patient B to be more self-reliant. The panel was of the view that the note of concern was in fact indicating that Patient B was requesting a change of care coordinator as he felt that he was getting too close to you. The panel specifically noted the following excerpt:

'Patient B twice requested change of worker. Difficult case and it is possible that this may have happened with another worker. We had discussed issues around boundaries with this service user several times early on.'

Further the panel was mindful that the fact that Witness 1 had stated in her note of the concern that *'the level of support was inconsistent, initially doing so much for him then not being able to respond the same way for all other needs',* could be interpreted as you attempting to support Patient B in being more self-reliant.

The panel took into account Patient B's RiO notes from 21 November 2019 to 6 April 2020. The panel noted that the contemporaneous notes did not evidence any occasion when you had not set clear boundaries, specific times for appointments or had not supported Patient B in being more self-reliant. In fact, the panel was of the view that the contemporaneous notes provided clear and cogent evidence that you had on numerous occasions set clear

boundaries, specific times for appointments and supported Patient B in being more self-reliant. The panel had specific regard to the following entries inputted by you on Patient B's RiO notes.

On 3 December 2019

'Patient B attended for his appointment…'

On 6 December 2019

'Contact from Patient B this morning saying he does not feel well and needs to see a Doctor, have sorted a letter for him to be picked up at Whitley Bay and told him to go to GP practice...'

On 13 December 2019

'…I asked Patient B to contact the crisis team or the police if he felt that he was in danger...'

On 16 December 2019

'Rang Patient B to see how he was as I said I would, he txt (sic) me asking to see me but I was unable to straight away as I had other work. I did offer him to come to Whitley Bay at 13:00 but he was not able'.

On 18 December 2019

'Patient B attended for a planned appointment.'

On 19 December 2019

‘Contacted Patient B to offer him an appointment at Whitley Bay in the morning…’

On 22 January 2020

‘Met with Patient B for scheduled appointment…’

On 5 February 2020

‘Met with Patient B for scheduled appointment’.

In light of the evidence provided in the contemporaneous RiO notes of Patient B and the content of the note of the concern raised by Patient B, dated 6 April 2020. The panel found charge 1, in its entirety, NOT proved.

Charge 2a

“That you, a registered mental health nurse, on a date on or around 28 January 2020:

a. Overshared personal information with Patient C and/or their mother

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and the letter she provided to Patient C’s mother. The panel had specific regard to paragraph 6 of Witness 1’s written statement in which it was stated by Witness 1 that Patient C’s mother *‘felt that Karen had overshared her own experience’.* The panel took into consideration that Witness 1 in her oral evidence stated you ‘*may have over-identified with the mother’* but that she did not have an opinion regarding whether this was oversharing.

The panel took into account your oral evidence, written statement and documentary evidence provided. The panel noted that you stated that you did accept that you disclosed some personal information to Patient C's mother, as you empathised [PRIVATE]. The panel was mindful that in your oral evidence you stated that there is research to suggest that it is beneficial to share personal experiences with patients and it accepted that you did not think your disclosure was *'oversharing'.*

The panel therefore noted that there is no dispute as to the fact that you disclosed personal information to Patient C's mother. However, there is a dispute as to whether this constituted *'oversharing'.*

The panel took into account Witness 1's response, dated 14 February 2020, to a complaint from Patient C's mother received on 28 January 2020, in which it is stated *'you [Patient C's mother] felt that Karen had shared some of her own personal experience* [PRIVATE]*, and you [Patient C's mother] found this unprofessional.'* The panel noted that in this complaint there is no reference to the fact that you *'overshared'.*

The panel noted that it had no direct evidence from Patient C's mother as to whether your disclosure constituted *'oversharing'*. The panel had regard to the fact that it only had the account of what Patient C's mother said to Witness 1.

The panel took into account Patient C's RiO notes from 14 January 2020 to 21 January 2020 and noted that there is nothing contained within them to evidence that you *'overshared'* but that there is evidence that you signposted resources to Patient C's mother [PRIVATE].

The panel determined that the NMC has not discharged its burden of proof in evidencing that you *'overshared',* given that the only evidence is provided by Witness 1 of a conversation she had with Patient C's mother in which there was no reference to *'oversharing'*, only that in Patient C's mother's opinion you had been unprofessional. The panel therefore found charge 2a NOT proved.

Charge 2b

"That you, a registered mental health nurse, on a date on or around 28 January 2020:

b. Did not send information relating to the completion of PIP assessment forms as promised."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement and supplementary statement. The panel had specific regard to paragraph 6 of Witness 1's written statement in which it was stated that Patient C's mother *'felt that Karen…had over promised by saying that she would send some information that she did not end up sending'.*

The panel took into account Patient C's RiO notes from 14 January 2020 to 21 January 2020 and noted your entry on 14 January 2020 in which you stated *'Not in receipt of any benefits. Discussed this with Patient C and her mum, advised to apply for universal credit and PIP'.* The panel noted your entry on 21 January 2020, in which you stated, *'I had said I could send her specific information to support her application for PIP'.*

The panel had regard to your oral evidence, written statement and documentary evidence provided and noted that you accepted that you would send Patient C's mother information regarding PIP and attempted to do so via email and that it bounced back, but subsequently you did send it. The panel noted that there is no evidence of this attempt to send the PIP information contained within the contemporaneous notes for Patient C.

The panel took into account Witness 1's response, dated 14 February 2020, to a complaint from Patient C's mother received on 28 January 2020, in which it is stated that you offered to do more for Patient C's mother than you would have otherwise, *'for example*

sending information about PIP', and then found out that you *'were not able to action this in a timely way'.*

Further the panel took into consideration that Witness 1 in her oral evidence stated that she sent information regarding applying for Personal Independence Payment (PIP) when she responded to Patient C's mother's complaint on 14 February 2020. The panel considered that it could therefore be inferred that Patient C's mother had still not received information regarding PIP on 14 February 2020.

The panel preferred Witness 1's account as it was clear, consistent and supported by contemporaneous documentary evidence. The panel therefore found on the balance of probabilities, charge 2b proved.

Charge 4b

> "That you, a registered mental health nurse, between 15 April and 30 June 2020:
>
> b. Did not fully record what had happened during your sessions with Patient F."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5ii of Witness 1's supplementary statement in which it was stated that for Patient F there was *'little evidence of what happened during sessions'.* The panel noted Witness 1's oral evidence in that it was *'not a full record'.*

The panel had regard to the caseload update produced by Witness 1 dated 11 June 2020 and Witness 1's supervision record for you dated 1 May 2020. The panel noted that

Witness 1 commented on Patient F but that there is no remark or information included to evidence that you were not fully recording what had happened during your sessions with Patient F at that time.

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you stated that *'all notes in RiO support my work'.*

The panel took into account Patient F's RiO notes from 15 April 2020 to 24 June 2020. The had specific regard to your entries on 21 May 2020 and 27 May 2020. The panel determined that your entries on Patient F's record were very detailed, including information on formulation, appointments, prescriptions, wellbeing and progress.

The panel determined that the NMC has not discharged its burden of proof, in that there is not sufficient evidence to support that, on the balance of probabilities, you did not fully record what had happened during your sessions with Patient F. The panel therefore found charge 4b NOT proved.

Charge 4c

"That you, a registered mental health nurse, between 15 April and 30 June 2020:

c. In relation to Patient H:
    i. Did not achieve contact with them.
    ii. Did not flag or raise a concern in relation to the lack of contact.
    iii. Did not try to assertively contact them."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5iv of Witness 1's supplementary statement in which it was stated that for Patient H *'over two months did not achieve contact and did not flag or raise concern, try to assertively contact'.*

The panel took into consideration your oral evidence, written statement dated 20 May 2024 and documentary evidence provided. The panel noted that you stated, *'this patient did not engage, was unable to contact him, did tell my manager',* and that you *'checked with GP to see if he was engaging/getting medications and he was'.*

In relation to charge 4ci and 4cii, the panel took into account Patient H's RiO notes from 15 April 2020 to 30 June 2020. The panel noted that within the contemporaneous notes there is no record of contact with Patient H and that there is nothing to suggest that a concern was raised regarding this lack of contact.

The panel noted that it is not disputed that you did not achieve contact with Patient H. The panel, therefore, found, on the balance of probabilities, charge 4ci proved.

The panel in light of the lack of contemporaneous evidence to support that you did flag or raise a concern in relation to the lack of contact, preferred Witness 1's evidence. The panel, therefore, found, on the balance of probabilities, charge 4cii proved.

In relation to charge 4ciii, the panel took into account Witness 1's oral evidence in that you did not try to assertively contact Patient H as you could have *'contacted their family…visited their home… contacted their GP… undertaken a welfare check… contacted the police'.* The panel took into consideration your oral evidence in that you felt *'you could not have done anything more',* that *'you can't force people to engage'* and *'the police were not required'*. Further the panel noted that you stated that you were content there was no cause for concern as you had contacted the GP practice.

The panel took into consideration the caseload update produced by Witness 1 dated 11 June 2020. The panel noted your entry in relation to Patient H *'I have tried several times to contact this man, checked with GP, he is getting his prescription for his antipsychotics so this is positive, have sent letter.'*

The panel took into account Patient H's RiO notes from 15 April 2020 to 30 June 2020. The panel noted your contemporaneous note on Patient H's records on 8 June 2020 in which you stated *'telephone call to Patient H, voicemail left. Contacted GP practice to see if Patient H was getting prescriptions or had been to see a Doctor recently. Last prescription requested on 1 June 2020 and was for correct medication.'* The panel was of the view that this was not an assertive attempt to contact Patient H as it would appear that you did not directly speak to his GP but only contacted the practice to see if he was requesting his medication. The panel noted your entries in the contemporaneous records of a few attempts to phone Patient H and an email request to administrative support to commission a letter asking Patient H to contact you.

The panel was of the view that there was clear and cogent evidence provided to it to demonstrate that there were other actions you could have undertaken to attempt to assertively contact Patient H and that there is no contemporaneous evidence provided to demonstrate that you did. The panel therefore found on the balance of probabilities charge 4ciii proved.

Charge 4d

> "That you, a registered mental health nurse, between 15 April and 30 June 2020:
>
> d. Had minimal contact with Patient L."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5viii in Witness 1's supplementary statement in which it is stated that for Patient L there was *'barely any contact over two months'* when you were the care coordinator.

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you stated you were told by Patient L's wife that he did not speak good English. You stated that Patient L *'did not want to engage'* and *'did not want help'*. You told the panel that *'you did as much as could'* and that there was nothing to suggest there were any issues after speaking to Patient L's wife.

The panel took into account Witness 1's oral evidence that it was your responsibility to speak to Patient L directly not just his wife and that you could have used an interpreter.

The panel had regard to Patient L's RiO notes from 15 April 2020 to 30 June 2020,
The panel noted that within the contemporaneous notes there is no record of any contact by you with Patient L himself, there is only a record that you spoke to his wife.

The panel noted that there is no dispute as to the fact that you did not contact Patient L directly. The panel therefore determined that you had minimal contact with Patient L and found charge 4d, on the balance of probabilities, proved.

Charge 5

> "That you, a registered mental health nurse, between 27 December 2019 and 30 June 2020, on one or more occasion, in relation to Patient G did not record that plans had been followed through."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5iii in Witness 1's supplementary statement in which it is stated that for Patient G there was *'no evidence of plans being followed through'.*

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you *'raised concerns with her psychiatrist…arranged for her to have appointments'* but that once the COVID-19 pandemic started Patient G *'did not want me [you] to visit, she told me [you] she was managing'.* Further the panel noted that you stated you signposted Patient G's daughter on how to apply for a carers assessment but that it was not for you to follow up on this.

The panel took into account Patient G's RiO notes from 27 December 2019 to 17 June 2020. The panel noted your entry on 19 March 2020, when you stated, *'referral for daughter re carers (sic) assessment'.* The panel noted your entry on 9 June 2020, when you recorded *'send information for her daughter to claim carers (sic) allowance'.* The panel was of the view that this indicated that you had not followed up regarding the daughter undertaking a carer's assessment in the intervening 3-month period and that there is nothing contained in Patient G's notes to evidence that this matter has been concluded. Further the panel noted that on 3 March 2020 it is stated that Patient G would undertake *'work with Karen on anxiety management, sleep hygiene'.* However, the panel determined that there are no entries in the contemporaneous supervision records or notes for Patient G to evidence that you followed up on this plan.

The panel was of the view that even if it was not your responsibility to follow up on a carer's assessment it was clearly your responsibility to follow up on the plan to undertake work with Patient G on anxiety management and sleep hygiene. The panel noted that the contemporaneous documentary evidence provided did not contain any entries from you that this had been undertaken. The panel therefore found on the balance of probabilities, charge 5 proved.

Charge 6

> "That you, a registered mental health nurse, between 29 April and 30 June 2020 had minimal contact with Patient I."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5v in Witness 1's supplementary statement in which it is stated that for Patient I there was *'minimal contact with new patient within 2-month period'.*

The panel took into consideration your oral evidence, written and documentary evidence provided. The panel noted that you stated you were on leave for the first two weeks of May 2020 and that you *'did make contact more than once'.*

The panel took into account Patient I's RiO notes from 29 April 2020 to 30 June 2020. The panel noted that within the contemporaneous notes for Patient I there are entries on the following dates when you contacted Patient I, 29 April 2020 and 28 May 2020.

The panel determined that as a purely factual matter that contacting a new patient only twice in a two-month period, taking into account your 2-week period of leave, constitutes *'minimal contact'*. The panel therefore found charge 6 proved.

Charge 7

> "That you, a registered mental health nurse, despite being allocated Patient J on or around 29 November 2019 did not ensure that their formulation was added to their record prior to 26 June 2020."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5vi in Witness 1's supplementary statement in which it is stated that for Patient J *'despite repeatedly stating that formulation was required this was not added to the record until the Registrant's last day in work (7 months after meeting the patient)'*

The panel had regard to Witness 1's supervision records for you dated 6 April 2020, in which Witness 1 stated *'Formulation to be typed up and then put forward for psychological work'.*

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you stated you were allocated Patient J in December 2019 and were working steadily together to accumulate information to do the formulation and that it was taking longer as she was unreliable with appointments.

The panel had regard to Patient J RiO notes from 29 November 2019 to 26 June 2020 and noted that there was no formulation inputted on Patient J's records prior to 26 June 2020, and that there is clear and cogent evidence that you were allocated as Patient J's care coordinator on or around 29 November.

The panel noted that you do not dispute this charge on a factual basis and therefore the panel found on the balance of probabilities, charge 7 proved.

Charge 8

> "That you, a registered mental health nurse, between 5 December 2019 and 30 June 2020 did not record evidence of any assessment or intervention around Patient K's mental health needs."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5vii in Witness 1's supplementary statement in which it is stated that for Patient K there was *'no evidence of any assessment or intervention around mental health needs throughout the 6 months she [you] was working with her.'*

The panel had regard to Witness 1's supervision records for you dated 6 April 2020 and noted that Witness 1 recorded *'Just monitoring currently. Looking for a period of stability and will consider discharge after COVID situation'.* The panel noted that Witness 1's supervision records for you dated 1 May 2020, also recorded discharge was the next step.

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that stated you did *'what was required of you',* you saw her regularly and attended medical reviews.

The panel had regard to Patient K's RiO notes from 15 December 2019 to 26 June 2020 and noted the entries by you on the record of calls which involved discussions and implementation of plans for future contact and/or arrangement of future appointments on 5 December 2019, 19 December 2019, 9 January 2020, 24 March 2020, 29 April 2020. The panel noted that on 27 February 2020 it was stated that the plan for Patient K was *'to continue to work with care coordinator Karen Brown'.* Further the panel noted that on 29 March 2020 it was stated that the plan for Patient K was *'continue to have more regular contact from her care-coordinator Karen Brown.'*

In light of the above, the panel was of the view that the evidence before it suggests that you were simply to keep in regular contact and monitor Patient K. The panel decided that there was no evidence before it to demonstrate that you were required to undertake any

assessment or intervention. The panel therefore determined that the NMC had not discharged its burden of proof and therefore the panel found charge 8 NOT proved.

Charge 9

> "That you, a registered mental health nurse, between 1 April and 30 June 2020 had minimal contact with Patient M and/or did not record that plans had been carried through."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 5ix in Witness 1's supplementary statement in which it is stated that for Patient M between the 1 May 2020 and 30 June 2020, there was *'minimal contact and no evidence of plans being carried through'.*

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you stated that you were allocated Patient M on 1 May 2020 and were away the first two weeks of May. Further that you stated you contacted Patient M *'as much as you could'* and *'arranged physical health check/review with psychiatrist'.*

The panel took into account Patient M's RiO notes from 1 May 2020 to 30 June 2020. The panel noted that on 1 May 2020 you called Patient M and explained that you were off on leave for two weeks but would contact him on your return. The panel noted that on 9 June 2020 you called patient M and stated you planned to arrange a medical review and set up a face-to-face appointment. Further the panel noted that the only other communication you had with Patient M was on 16 June 2020 when you called him and informed him you were leaving the Trust, and he informed you he was happy that a medical review was arranged.

Further the panel noted that Patient M was *'struggling at times'* and that he was going through a *'difficult'* period.

The panel was of the view that the date in the charge was made in error as all the evidence indicated that the period of time during which Patient M was in your care was 1 May 2020 to 30 June 2020. The panel noted upon the evidence provided that you contacted Patient M, 3 times in a 2-month period. The panel determined, that given that Patient M was struggling at the time and taking into consideration your two-week period of leave in May, that this still constituted *'minimal contact'* on a purely factual basis.

The panel determined upon the evidence, that there is no record that you had a face-to-face meeting with Patient M, nor is there a record that you arranged a medical review, although it does appear that this was carried out.

The panel in light of the contemporaneous notes, found on the balance of probabilities, charge 9 proved.

Charge 10

> "That you, a registered mental health nurse, between 3 December 2019 and 30 June 2020, in relation to Patient O:
>
> b. Recorded minimal information about assessment of their mental health and/or their formulation and/or treatment plan."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 7i in Witness 1's supplementary statement in which it is stated that for Patient O *'Contact with this patient was predominantly around*

alcohol use and housing, despite the patient accessing NTRP [North Tyneside Recovery Partnership] and having various other support agencies involved re housing. Little if any evidence of assessment of mental health or mental health treatment needs from the CTT, and no evidence of formulation or treatment plan. Supervision notes state from the beginning that we need a formulation.'

However, the panel noted that there is no evidence contained in the supervision records provided by Witness 1 to demonstrate that a formulation was required. Further there is nothing within the supervision notes evidencing that you were not recording sufficient information regarding Patient O's assessment of mental health and/or formulation and/or treatment plan.

The panel took into consideration your oral evidence, written statement dated 20 May 2024 and documentary evidence provided. The panel noted that you stated you *'supported her with her housing application'* and that you felt that she did not need to be with the CTT team, she was receiving help from other professional treatment teams.

The panel took into account Patient O's RiO notes from 3 December 2019 to 30 June 2020 and noted that there are clear consistent entries by you in the notes of Patient O demonstrating that you had undertaken mental health assessments. The panel noted on 12 December 2019 you undertook a Mental Status Examination and provided sufficient information regarding this assessment. On 9 January 2020, Witness 1 made an entry stating you had undertaken a clinical assessment. On 14 January you undertook a Mental Status Examination and provided sufficient information regarding this assessment. The panel noted the contemporaneous notes for Patient O also evidenced you having undertaken treatment plans by carrying out a *'5P'* formulation and liaising with other agencies/professionals. The panel was satisfied that all of your entries on patient O's notes had sufficient detail.

The panel in light of the circumstances of Patient O and the corroborating contemporaneous evidence. The panel therefore found on the balance of probabilities charge 10b NOT proved.

Charge 11

> "That you, a registered mental health nurse, in relation to Patient P, stated in supervision that the main focus would be on assisting them to locate their brother's burial/cremation details."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 7ii in Witness 1's supplementary statement in which it is stated that for Patient P, *'in supervision, the Registrant said that the main focus of the work would be to help him locate his brother's burial/cremation details.'* The panel noted that Witness 1 when questioned in her oral evidence stated that her memory was hazy and that it may have been said in a passing comment.

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you were clear and consistent in your account that the task of attempting to locate Patient's P's brother's burial/cremation details to help him get closure was not instigated by you but by the Patient P's worker in the forensic team.

The panel took into account Patient P's RiO notes from 28 April 2020 to 30 June 2020, and noted the records inputted by you, which included the forensic worker's emphasis on securing Patient P's brother's burial/cremation details. The panel determined that the records do not evidence that your main focus was finding Patient P's brother's burial/cremation details. Further the panel noted that the charge indicates that this was

‘stated in supervision’. However, the panel noted that there is nothing contained within the supervision records to indicate that you said that your main focus was to locate Patient P’s brother’s burial/cremation details.

The panel determined that the NMC has not discharged its burden of proof on the balance of probabilities and therefore the panel found charge 11 NOT proved.

Charge 12

> “That you, a registered mental health nurse, between 6 January and 18 June 2020, in relation to Patient R, did not properly consider the treatment plan and/or record that it was being followed through.”

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 12i in Witness 1’s supplementary statement in which it is stated that for Patient R *‘ultimately, we had to get the psychologist involved to complete the formulation as there was an emerging diagnosis and it was unclear what the best treatment pathway was. This could have been at least started by the Registrant, she alluded to it in her records but there is no evidence of it being done’.* The panel noted that in her oral evidence Witness 1 stated that there was a formulation but not a full one.

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you stated there was a lack of clarity regarding Patient R’s diagnosis.

The panel took into consideration Patient R’s RiO notes from 6 January 2020 to 18 June 2020, and noted that there is nothing to evidence that there was a clear patient care plan. The panel had regard to your entries on 7 February 2020, 17 February 2020, 27 February

2020 and 3 March 2020, in which you discuss '*5P'* formulation with Patient R and attempt to start it.

Further the panel took into account Witness 1's supervision records for you dated 1 May 2020, in which it was stated *'formulation to be typed and uploaded'* as well as the caseload update provided by Witness 1 dated 11 June 2020, in which it is stated *'formulation complete, needs referral to psychosis pathway. Currently doing well'.*

The panel therefore concluded that you had properly considered a treatment plan as you were discussing and attempting to start a formulation for Patient R. The panel however determined that the evidence demonstrates that Patient R's diagnosis was unclear and therefore it was unclear as to what treatment plan had been agreed.

The panel therefore determined that the NMC has not discharged its burden of proof in relation to demonstrating that there was a clear treatment plan and therefore the panel found charge 12 NOT proved.

Charge 14a

"That you, a registered mental health nurse, on 28 May 2020:

a. Despite being asked to no longer work with Patient D, left a voicemail on their phone and/or attended their home address.

This charge is found proved.

In reaching this decision, the panel first determined that upon the evidence there is no dispute as to the fact that you left a voicemail on Patient D's phone and/or attended their home address. However, there is a dispute regarding whether you did this despite being asked to no longer work with Patient D.

The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 11 in Witness 1's written statement in which it is stated that Patient D had asked to have you removed as her care coordinator. The panel also noted that Witness 1 states *'When I removed Karen from this Patient's care I told Karen not to have further contact with the Patient'.* Further the panel noted that Witness 1 in her oral evidence confirmed that she informed you that you were no longer to arrange appointments with Patient D.

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you stated you understood that you were no longer to offer appointments but that you were on the on-duty care coordinator when a telephone call came in and therefore had responsibility to do something.

The panel took into account Patient D's RiO notes from 3 December 2019 to 1 June 2020 and noted that you were not working with Patient D at the time of the alleged incident. The panel had specific regard to Witness 1's entry on 3 January 2020 in which is it clearly stated that Patient D requested a change of care coordinator and that Witness 1 would discuss this with you and ask you not to offer further appointments. Further the panel noted that the change of care coordinator is evidenced in Patient R's notes.

The panel therefore determined that it is agreed that you were aware that you were no longer to work with Patient R or to offer any appointments and therefore on a factual basis the panel found charge 14a proved.

Charge 15c

"That you, a registered mental health nurse, in relation to Patient A:

c. Did not arrange for carer help and/or for a social care package to be put in place."

This charge is found NOT proved.

In reaching this decision, the panel bore in mind that charge 15a and charge 15b have been found proved by your admission.

The panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel noted that Witness 1 in her oral evidence stated that if charge 15a and charge 15b were tasks that Patient A needed assistance with, then a social care package should have been in place. The panel noted that there is no evidence that a social care package was discussed in supervision nor in relation to a treatment plan.

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you stated that you did refer Patient A to adult social care, to get help from a social worker, and it was refused.

The panel took into account Patient A's RiO notes from 28 November 2019 to 30 June 2020 and noted that there were numerous entries by you evidencing your attempts to arrange for social prescribers/carer help and that there was no evidence to indicate that a social care package was required.

The panel was of the view that you had attempted to arrange for carer help and/or social worker help but that in any event the NMC has not discharged its burden of proof in that there was no evidence presented to the panel by the NMC to support that a social care package was required. The panel therefore found charge 15c NOT proved.

Charge 15f

"That you, a registered mental health nurse, in relation to Patient A:

f. Did not record any conversations with Patient A and/or social services about being the birthing partner of A."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 provided in her oral evidence, written statement, supplementary statement and supervision records. The panel had specific regard to paragraph 17 of Witness 1's written statement, in which it was stated that *'Karen had not recorded any conversations with Patient A or with social services about this [being the birthing partner of Patient A]'.*

The panel took into account Witness 2 and Witness 3's evidence in that there were discussions regarding you being a birthing partner for Patient A but that there are no records of these discussions.

The panel took into consideration your oral evidence, written statement and documentary evidence provided. The panel noted that you stated discussions had taken place regarding you being the birthing partner but at the time of leaving this had not been confirmed. Further you stated you did make entries regarding this but that they are missing.

The panel took into consideration Patient A's RiO notes from 28 November 2019 to 30 June 2020. The panel noted that on 26 June 2020, you copied in an email to Witness 3 regarding discussions around being a birthing partner to Patient A and encouraging her to lean on her cousin more as a potential birth partner. The panel also noted that on 26 June 2020, you stated *'From further discussions with Patient A's social worker it has been agreed for me to be added to the birth plan of Patient A*'. The panel determined that upon

inspection of Patient A's contemporaneous notes there is no record of these discussions with Patient A and/or social services about being a birthing partner of Patient A.

The panel determined in light of the witness evidence and contemporaneous documentary evidence that on the balance of probabilities, charge 15f was found proved.

Charge 16

> "Your actions at charges 1 and/or 2 and/or 3 and/or 15 breached professional boundaries."

This charge is found proved.

The panel carefully considered whether this charge would be best dealt with at the misconduct stage. However, the panel reached the decision that it will deal with this charge on a purely factual basis at this stage and will consider contextual circumstances and the seriousness of any breaches of professional boundaries found proved at a later stage.

Charge 1, in its entirety, and charge 2a were not considered by the panel as they had already been found NOT proved.

The panel determined that your actions at charge 2b, charge 3a and charge 3b were not in breach of professional boundaries. The panel noted that there was no factual evidence presented to it to support that your actions at charge 2b, charge 3a and charge 3b were in breach of professional boundaries, in fact Witness 1 in her oral evidence stated in her view your actions at charge 2b, charge 3a and charge 3b were NOT in breach of professional boundaries.

In respect of charge 15e and charge 15g, Witness 1, Witness 3 and Witness 4 were all of the view that your actions were in breach of professional boundaries. Further the panel noted that you accepted that in hindsight you would have acted differently.

The panel therefore on a factual basis found charge 16 on the balance of probabilities, proved, in respect of charge 15e and charge 15g.

At the outset of the resumed hearing on 22 October 2024, the panel was informed that you had a new representative. Mr Hussain-Dupre, acting on your behalf, indicated that there were matters relating to the charges, the evidence and your previous representation that he wished to place on the record and the panel gave him permission to do so. He accepted, however, that the panel had made a decision on the facts and that he could not make any applications in relation to those matters. Additionally, Mr Hussain-Dupre made an application requesting that the panel consider misconduct and provide a written determination, before proceeding to impairment. He argued that this approach would enable you to focus more effectively on preparing your case in relation to current impairment.

Mr Segovia did not object to this application.

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

The panel decided to grant Mr Hussain-Dupre's application. It would consider whether the facts found proved amount to misconduct and hand down its decision before moving on to hear your evidence and submissions on impairment if misconduct is found.

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.

The panel, in reaching its decision, has recognised the 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.

Submissions on misconduct

Mr Segovia 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 in making its decision.

Mr Segovia referred the panel 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 Segovia submitted that the central issue in this case revolves around determining whether the facts the panel have found proved, or those admitted and confirmed, amount to professional misconduct. He said that this is entirely the panel's decision, and in reaching its decision the panel can refer to the Code and case law to guide its understanding of what amounts to a professional misconduct.

Mr Segovia submitted that it is crucial to focus on the underlying issue, as highlighted by Witness 1. He said that she described a polarising difference in your care. For some patients, you went beyond your role, spending excessive time, while for others, you failed to provide necessary care, resulting in inconsistent service. Witness 1 also stated that you blurred the boundaries between patient and care coordinator, potentially making patients overly reliant on the service. Mr Segovia submitted that the charges reflect these themes. For example, charge 2b addresses a failure to fulfil a promise, while charge 3 demonstrates overstepping professional boundaries by taking on tasks that patients should handle themselves. Similarly, charges 4, 5, 6, and 7 highlight your inconsistent contact with patients, neglecting some while over-involving yourself with others. He said that the lack of proper record-keeping and delays in key actions further emphasise these issues.

Mr Segovia submitted that in relation to charge 14, where you, despite being instructed not to work with a particular patient, continued your involvement unnecessarily. This reflects the core problem, you repeatedly overstepped your role and failed to provide a consistent,

appropriate level of care to all patients under your responsibility.

Mr Segovia stated that charge 15, as the panel found, relates to you agreeing to be a birthing partner, attending the birth of a child, and caring for children which were actions far outside your professional role. He said this is a significant breach of professional boundaries, as highlighted by Witness 4's evidence. Witness 4 expressed concern that your behaviour blurred the lines between personal and professional roles, leading to confusion for a highly vulnerable patient. He said that Patient A, who was no longer under your care, became confused and distressed, feeling betrayed and judged and this was all due to your actions. This breach went beyond being an advocate or friend—it was a clear overstepping of your professional responsibilities and put Patient A at a real risk of harm.

Mr Segovia submitted that paragraph 20.6 of the Code underscores the importance of maintaining professional boundaries, even with former patients. He submitted that your actions violated this principle, jeopardising not only Patient A's well-being but also the reputation of the profession. He submitted that agreeing to be a birthing partner and looking after a former patient's children was a serious error in judgment, creating a situation where Patient A became confused about your role as a registered professional.

Mr Segovia submitted that this serious breach of boundaries, compounded by similar issues in charge 15, where you overstepped your duties by taking a patient's children to playgroup and doing shopping for them, reflects a pattern of inconsistent care. He said that some patients received too much attention, while others were neglected, demonstrating a lack of coherent, structured care. He submitted that these breaches represent a fundamental failure to uphold professional standards.

Mr Hussain-Dupre submitted that the key question for the panel is whether the proved facts amount to conduct that would be regarded as deplorable by fellow professionals, as established in the *Meadow* case referencing *Nandi v General Medical Council* [2004] EWHC 2317 (Admin)

Mr Hussain-Dupre invited the panel to consider that the facts relating to charges 2-14 do not inherently indicate wrongdoing or breaches of an obligation. He submitted that these charges are presented as assertions of fact rather than allegations of misconduct. For example, while it is suggested that you showed inconsistencies in the level of care provided, these inconsistencies are not directly reflected in the charges. Thus, the narrative of doing more for some patients and less for others does not form the basis of the charges themselves.

Mr Hussain-Dupre submitted that your job description, as outlined in the case documentation, indicates that your role involved providing holistic and compassionate care, often in challenging conditions, such as the COVID-19 pandemic, when resources were limited. Given these circumstances, your actions, such as assisting patients with medication or liaising with GPs, are arguably reasonable responses to the acute needs of your patients, rather than instances of misconduct. He submitted that your efforts to assist patients with mobility issues, including obtaining medication and supporting their access to healthcare, should be seen as appropriate given the difficult circumstances the patient faced.

Mr Hussain-Dupre submitted that in respect of the charges relating to limited patient contact, you made reasonable attempts to contact patients during a challenging period, and there is no evidence suggesting that you were required to take further steps. For instance, in charge 4c, where you left voicemails and arranged for letters to be sent, there is no evidence of policy breaches. In charge 5, you did follow up with a high-risk patient by arranging a psychiatric review and documenting ongoing care. Mr Hussain-Dupre submitted that the charges do not establish a failure to meet professional standards or wrongdoing on your part. The panel is reminded that, while hindsight may suggest alternative actions, your decisions were based on your professional judgment and available resources during an unprecedented time.

Mr Hussain-Dupre submitted that the actions in relation to charges 7 and 9 reflect a diligent and professional approach to patient care. In charge 7, you accumulated the

necessary information to support Patient J, a complex case, despite challenges with the patient's unreliability and lack of external support. Mr Hussain-Dupre submitted that your steady work led to a critical formulation being entered, which could only have stemmed from your efforts. In relation to charge 9, despite limited time due to you being on annual leave, you established meaningful contact, arranged medical reviews, and fulfilled your duties to the patient.

Mr Hussain-Dupre submitted that in relation to charge 10, your involvement in supporting a housing issue for Patient O was well within your role as a care coordinator, addressing broader circumstances impacting patient wellbeing. He submitted that such a proactive approach reflects your commitment to holistic patient care.

Mr Hussain-Dupre submitted that charge 14 addresses an incident where you were instructed not to work with Patient D but felt obligated to act when no other colleagues were available, and serious concerns had been raised about the patient's child and a dog’s welfare. He submitted that despite your instructions, you had acted responsibly due to the urgency and lack of alternative support, which aligned with your duty to safeguard patients.

Mr Hussain-Dupre submitted that in relation to charge 15, during the pandemic, you managed multiple complex cases, including vulnerable adults with housing and childcare issues. He submitted that you engaged various services and took immediate action where necessary, always prioritising patient safety and wellbeing. Notably, you supported Patient A with day-to-day needs during COVID-19, attempted to coordinate a care package for her newborn baby, and reinforced positive behaviour. He submitted that while there were minor issues, such as an incomplete handover and temporary care for a child, your actions were rooted in compassion and a desire to help a patient when no other support was available.

In conclusion, Mr Hussain-Dupre submitted that you had acted within the scope of your role, addressing the acute needs of your patients during challenging circumstances. He

submitted that your conduct does not amount to serious professional misconduct and would not be considered deplorable by fellow practitioners familiar with the pressures and complexity of your role as a care coordinator.

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

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 some of your actions did fall significantly short of the standards expected of a registered nurse and amounted to breaches of the Code.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered the charges individually and collectively in respect of misconduct.

Charge 2b – misconduct NOT found

In respect of charge 2b, the panel noted that the failure to forward information relating to the completion of a PIP assessment form was an oversight on your part and did not pose a risk of potential harm to the patient. Additionally, the panel acknowledged that you had offered to do this voluntarily and that it was not part of your role as a care coordinator. The panel did not consider your failure to send Patient C this information amounted to misconduct.

Charges 3a and 3b – misconduct NOT found

In respect of charge 3a, the panel was of the view that your conduct reflects the multifaceted nature of care coordination, particularly in the challenging context of the COVID-19 pandemic when limited resources were available. The panel determined that it is evident that you acted with the patient's best interests in mind when you picked up their medication from the pharmacy and contacted the GP on their behalf. The panel was of the view that whilst this may not be considered as optimal use of a Band 6 nurse, you were addressing the needs of a vulnerable patient in order to ensure that the patient received their necessary medication.

The panel concluded that your actions in picking up a patient's medication and contacting the GP on their behalf did not amount to misconduct.

Charges 4a, 4ci, ii and iii and 4d – misconduct NOT found

In relation to charge 4a, the panel noted that Patient E was unwilling to engage, despite multiple attempts made by you to contact them. It noted that you had recorded this in Patient E's notes. The panel did not consider that this amounted to misconduct.

In respect of charge 4ci, ii and iii, the panel determined that you made several attempts to contact Patient H, including phone calls and emails, but received no response. It also noted that you checked with Patient H's GP to confirm that they were receiving their medication.

The panel noted that your failure to contact Patient H was addressed with you in a supervision meeting. The panel did not consider that your failures in relation to charges 4ci, ii and iii were serious departures from the standards expected of a registered nurse. The panel did not consider that your failures amounted to misconduct.

In relation to charge 4d, the panel was of the view that it was appropriate for you to engage with the family regarding Patient L's wishes to transfer their care to another GP. Given the context, particularly this being in the early stages of the COVID-19 pandemic, the panel was of the view that while there may have been opportunities for enhanced support for Patient L, your failure to have more contact with them did not amount to misconduct.

Charge 5 – misconduct found

In respect of charge 5, the panel noted that you did not record that plans had been followed through in respect of sleep hygiene and anxiety management. The panel acknowledged that you may have engaged with these two plans but there is nothing recorded in Patient G's notes.

The panel determined that your failure to record that the plans had been followed through in Patient G's notes constitutes a breach of the Code, particularly concerning the requirement to maintain clear and accurate records relevant to one's practice as outlined in Paragraph 10.1 of the Code *'complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event'*

The panel was of the view that given that the patient in question was a vulnerable individual with mental health challenges, the recording in relation to these plans was essential to ensure continuity of care.

The panel determined that your failure to document relevant information in relation to the plans could have exposed Patient G to a potential risk of harm. The panel determined that your failure to record that the plans had been followed through was a serious departure from the standards expected of a registered nurse and amounted to misconduct.

Charge 6 – misconduct NOT found

In respect of charge 6, the panel determined that while you could have made more of an effort to contact Patient I, they were interacting with other professionals. The panel also noted that there was no evidence before it as to how much engagement you should have been having with Patient I, given the support that they were receiving from other professionals.

The panel determined that whilst you could have had more contact with Patient I, your failure to do so is not so serious to amount to misconduct.

Charge 7 – misconduct found

In respect of charge 7, the panel noted that Patient J was allocated to you, and it was part of your responsibilities to formulate a care plan for them and add that formulation to Patient J's records.

The panel determined that the lack of a formulation within Patient J's records over a period of seven months deprived other professionals of the clarity required to understand Patient J's specific care needs. This breached paragraph 10.1 of the Code *'complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event'*

The panel was of the view that your failure to add the formulation was a significant departure from the standards expected of a registered nurse and amounted to misconduct.

Charge 9 – misconduct found

In respect of charge 9, the panel was of the view that Patient M's notes lack documentation of sufficient interaction, despite the fact that Patient M was clearly

struggling with mental health issues at the time. The panel was of the view that, given their difficulties, you should have maintained more frequent contact with Patient M.

The panel was also of the view that your failure to document any efforts made by you to contact Patient M in their notes, or record the plans that had been carried through was unacceptable. Without proper records, other professionals would be unaware of the care being planned and provided, putting Patient M at a potential risk of harm. The panel determined that your failure to record that plans had been followed through was a clear breach of paragraph 10.1 of the Code *'complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event'*

The panel determined that given the particular circumstances of Patient M, your failures were a serious departure from the standards expected of a registered nurse and amounted to misconduct.

Charge 10a – misconduct NOT found

In respect of charge 10a, the panel considered that assisting a patient with a housing issue may be considered to be a necessary aspect of care, as long as it is not to the detriment of other tasks. The panel determined that, although this focus may have impacted your time management and other responsibilities, it is not such a serious departure from the standards expected of a registered nurse to amount to misconduct.

Charges 14a and 14b – misconduct found

In respect of charges 14a and 14b, the panel noted that you attended Patient D's address and left a voicemail on their phone regarding a concern about the patient's dog. The panel also noted that you failed to notify your manager, make any record of the visit or involve any other services. Patient D was a former patient of yours and you had been instructed to have no further contact with her. The panel was of the view that your actions in attending at Patient D's house and leaving a message on their phone could have caused distress to

Patient D. Further, your failure to inform your manager or make a record of your actions were serious failings. The panel was of the view that your conduct constituted clear breaches of the Code, particularly the following paragraphs:

> *'8.2 maintain effective communication with colleagues'*
> *'8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff'*

The panel determined that your actions and failings in relation to Patient D were serious departures from the standards expected of a registered nurse and amounted to misconduct.

Charge 15a – misconduct NOT found

In respect of charge 15a, the panel determined that you took Patient A to playgroup in order to assist them. The panel determined that as this only occurred on one occasion and was done in the best interests of Patient A, your conduct did not amount to misconduct.

Charge 15b – misconduct NOT found

In respect of charge 15b, the panel considered the circumstances surrounding Patient A, who was hospitalised, pregnant, and preparing to give birth during the COVID-19 pandemic. The panel was mindful that you openly admitted to taking Patient A shopping as they did not have transport themselves.

The panel considered the complexity of Patient A's clinical presentation, and determined that, given the facts, your actions in providing assistance to Patient A by taking them shopping during the exceptionally challenging time of the pandemic, did not amount to misconduct.

Charge 15di and ii – misconduct NOT found

In relation to charge 15di and ii, the panel was of the view that the issue of whether Patient A could have resolved the matter independently is fundamentally a matter of clinical judgment. The panel considered that in your judgement you were acting in the best interests of Patient A. The panel was of the view that whilst your actions may have exceeded the scope of your duties, they were not a serious departure from the standards expected of a registered nurse and did not amount to misconduct.

Charge 15e – misconduct found

The panel was of the view that your conduct crossed the professional boundaries between nurse and patient. This was both in relation to agreeing to be the birthing partner whilst Patient A was in your care and subsequently attending the birth of their child after you had left your role as care coordinator. It was of the view that fellow professionals would find this conduct very concerning, particularly given the vulnerability and clinical presentation of Patient A.

The panel determined that you breached professional boundaries in agreeing to be and subsequently acting as the birthing partner for Patient A without the necessary approval. The panel considered that your conduct breached the following paragraphs of the Code:

> *'8.2 maintain effective communication with colleagues'*
>
> *'20.1 keep to and uphold the standards and values set out in the Code*'
>
> '*20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers'*

The panel determined that your actions fell significantly short of the standards expected of a registered nurse and amounted to misconduct.

Charge 15f – misconduct found

The panel noted that you failed to record any conversations that you had with Patient A or social services about being Patient A's birthing partner. The panel considered that as Patient A's care coordinator, you were responsible for documenting why Patient A wanted you as their birthing partner, and recording any discussions that you had with social services regarding this plan.

The panel was of the view that given the intimate and serious nature of this role for a vulnerable patient with mental health problems, full and detailed records should have been made. The panel determined that your failure to document this information was a serious departure from your professional duties. The panel considered that your conduct breached the following paragraphs of the Code:

> *'8.2 maintain effective communication with colleagues'*
>
> *'8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff'*
>
> *'8.6 share information to identify and reduce risk'*
>
> *'10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event'*
>
> *'10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need'*

The panel determined that your failure to record this important information in Patient A's notes was a serious departure from the standards expected of a registered nurse and amounted to misconduct.

Charge 15g – misconduct found

The panel was clear that while you were no longer the care coordinator for Patient A when you looked after their children at your house, there remained a power imbalance due to your previous nursing role as care coordinator for this patient and your knowledge of their vulnerability and mental health needs.

The panel was of the view that caring for Patient A's children in your home breached paragraph 20.3 of the Code *'be aware at all times of how your behaviour can affect and influence the behaviour of other people'.* The panel was of the view that your actions could have adversely affected Patient A's behaviour, their vulnerability and their independence.

The panel also determined that you failed to maintain clear professional boundaries with Patient A, as required by paragraph 20.6 of the Code *'stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers'.*

The panel considered that a fellow professional would find your actions wholly inappropriate. It determined that your action in looking after Patient A's children was a serious departure from the standards expected of a registered nurse and amounted to misconduct.

Charge 15h – misconduct NOT found

The panel acknowledged that you had a very limited time available to provide a proper handover to Colleague 1. However, it noted that there was information available in the patient's notes and accessible to Colleague 1. The panel was of the view that whilst you

did not give a detailed verbal handover, patient notes provided the basis for continuity of care.

The panel concluded that in these circumstances your failure to give a proper handover was not so serious as to amount to misconduct.

Charge 16 – misconduct found

In respect of charge 16, the panel has already determined that charges 15e and 15g amounted to breaches of professional boundaries and misconduct. It involved the same breaches of professional boundaries by you and amounted to misconduct.

Collective misconduct NOT found

The panel considered all the charges that were found proved but did not individually amount to misconduct. In reviewing these collectively, the panel acknowledged that you had made several errors during your time as a care coordinator.

The panel took into account the challenging circumstances in which these errors had taken place, particularly during the early stages of the COVID-19 pandemic when there were limited resources and support available. Additionally, the panel noted that you had participated in regular supervision meetings, none of which appeared to identify the concerns that were subsequently reported as the result of a retrospective audit of patient records.

The panel determined that your errors did not indicate a repeated pattern of behaviour in any particular area of care that would be deemed serious enough to collectively amount to misconduct.

Submissions on impairment

Mr Segovia reminded the panel that it had found your actions and omissions constituted a number of serious breaches of professional standards, each reflecting a significant departure from the code of conduct. In particular, it had found that your failure to maintain accurate records could have led to lapses in patient care and a potential risk of harm to patients. He submitted that the following findings of the panel were important:

> **Charge 5**: There was a serious failure in record-keeping, exposing Patient G to risk of harm.
> **Charge 7**: The seven-month delay in documenting Patient J's formulation left other professionals without knowledge of the patient's needs.
> **Charge 9**: The failure to document care planning meant that other professionals were not aware of what plans were in place.
> **Charge 14a and 14b**: Attending Patient D's home and leaving them a voicemail, without recording this or informing your manager, could have caused Patient D unwarranted distress.
> **Charge 15**: The lack of detailed records about your plan to act as the birthing partner for a previous vulnerable patient (Patient A) meant that other professionals undertaking their care were unaware of your role.

Mr Segovia submitted that your actions in being the birthing partner and a childcare provider for a former patient (Patient A), constituted severe breaches of professional boundaries, particularly given your previous caring role and your awareness of Patient A's mental health difficulties. He submitted that your continued actions in relation to Patient A, despite no longer being Patient A's care coordinator, were both inappropriate and concerning.

Mr Segovia submitted that your insight and your understanding of professional boundaries and record-keeping requirements were inadequate. He said the written submissions made by your representative lacked clarity on this key aspect, suggesting a potential ongoing

risk. He submitted that your lack of full insight into these issues reflected an underlying attitudinal problem, not just a training deficiency. Mr Segovia further submitted that your failure to recognise the importance of maintaining professional boundaries was a serious concern.

Mr Segovia submitted that ultimately, while COVID-19 provided some context in relation to your misconduct, it was not a sufficient reason to mitigate the identified breaches, particularly concerning the professional boundaries issue. He submitted that your fitness to practise is currently impaired on the grounds of public protection. Mr Segovia also submitted that there is a need to maintain public confidence in the profession and its integrity and therefore your fitness to practise is also impaired on the grounds of public interest.

Mr Hussain-Dupre provided the panel with written submissions which are summarised as follows:

Mr Hussain-Dupre reminded the panel that your misconduct took place in late 2019 and early 2020 and that since that time you have continued work without further concerns or restrictions and you are currently in a non-nursing role supporting vulnerable women and families. He informed the panel that your current employer is aware of the regulatory issues and remains supportive of you. He referred the panel to the written testimonials provided by work colleagues that highlight your professionalism and dedication to patient care, especially during your last nursing role.

Mr Hussain-Dupre submitted that you have completed relevant training on professional boundaries and have reflected extensively on the incidents. He informed the panel that [PRIVATE]. He submitted that it was relevant that you had worked as a nurse for 37 years without any previous regulatory issues and 3 years subsequently without any further issues. Mr Hussain-Dupre further submitted that you are deeply saddened by the findings of misconduct made against you and that you had always aimed to provide high standards of care for your patients. He submitted that you acknowledged, in retrospect, that some of

your actions could have been handled differently but he emphasised that your conduct was not due to incompetence or a lack of empathy for your patients.

Mr Hussain-Dupre invited the panel to consider the context, which, at the time, included high patient numbers and limited support due to the COVID-19 pandemic. He submitted that the incidents had not been flagged up during regular supervision meetings, only through a retrospective audit. Mr Hussain-Dupre submitted that your conduct had been scrutinised to determine whether your actions compromised patient safety, breached professional standards, or undermined public confidence in the profession. He submitted that the NMC's assertion that you had prioritised some patients over others was not supported by the panel's findings.

Mr Hussain-Dupre referred to a number of legal authorities that he submitted would assist the panel in determining current fitness to practise. He submitted that the panel must assess whether the misconduct can be remediated, if it has been remedied, and whether repetition is highly unlikely. Mr Hussain-Dupre submitted that given your reflection and training you have effectively addressed all of these areas. He further submitted that a finding of impairment would be inappropriate as there has been no repetition, which must be considered an indicator of future risk. Mr Hussain-Dupre submitted that this case did not involve a deep-seated attitudinal problem; that the misconduct was capable of remediation and that it had been fully remediated.

In relation to the charges relating to your poor record keeping, Mr Hussain-Dupre submitted that although continuity of patient care could have been compromised, there was no finding that it was.

In relation to attending Patient D's house and leaving a voicemail, Mr Hussain-Dupre submitted that you had acted through a misplaced concern for the dog and that your focus should have been on the needs of the patient, which would have been best served by not contacting Patient D. He submitted that you did not intend to cause any distress to Patient D.

Mr Hussain-Dupre submitted that in relation to your breaches of professional boundaries, you had accepted that your actions were not appropriate in the context of your role as a nurse and the requirements of the Code. He reminded the panel that you are clear that should such a situation arise in the future, you would not adopt the same approach. He submitted that the fitness to practise process had served as a salutary lesson to you in terms of the importance of professional boundaries.

Mr Hussain-Dupre submitted that neither public protection nor public interest grounds were engaged to the extent that a finding of current impairment was necessary. He invited the panel to conclude that, taken in the round, your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor.

Decision and reasons on impairment

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

In reaching its decision on current impairment the panel had regard to the guidance on impairment set out in the NMC Fitness to Practise Library, updated on 27 February 2024, 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. To justify that trust, nurses must be honest and open and act with integrity. 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 Paula Grant* [2011] EWHC 927 (Admin) in reaching its decision. At 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.'*

At 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel carefully considered your misconduct in relation to working cooperatively with your colleagues, in particular in relation to your poor record-keeping. It concluded that your failure to document critical information involving vulnerable patients was a serious failing that put vulnerable individuals at unwarranted risk of harm. The panel was of the view that the absence of relevant and important information in the patients' records could have prevented other healthcare professionals from making informed, timely decisions regarding patient care and, therefore, potentially compromised patient safety.

The panel also considered that your conduct in leaving a voicemail, having been instructed not to make contact with Patient D, on their phone following an unauthorised visit to their home could have caused Patient D distress and upset. It was of the view that your failure to follow instructions not to contact Patient D had put them at unwarranted risk of harm.

With regard to your breaches of professional boundaries in relation you agreeing to act, and subsequently acting as a former patient's birthing partner and in providing care to their children, the panel noted the evidence before it that your actions had led to confusion, distress, and issues around boundaries for Patient A. In the panel's view your actions had compromised your former professional relationship with Patient A and this had adversely affected their trust in, and interaction with, other professionals involved in their care. The panel was of the view that your conduct had put Patient A at unwarranted risk of harm.

The panel noted its finding that you had breached a number of paragraphs of the Code, specifically paragraphs 8.2, 8.3, 10.1, 10.2, 20.3, and 20.6 and, in particular, that there

were repeated breaches in respect of your failure to work cooperatively with colleagues by not recording important information in patients' records. It was of the view that these breaches signified a substantial departure from the Code, which sets out the standards required for registered nurses. The panel was, therefore, satisfied that you had, in the past, breached fundamental tenets of the nursing profession.

The panel was satisfied that your misconduct had brought the nursing profession into disrepute as your failings were wide-ranging and your failure to record important information in patient records was repeated in relation to a number of vulnerable patients.

In light of the above, the panel determined that limbs a, b and c of *Grant* were engaged in the past.

The panel next considered the test set out in the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) for considering current impairment:

> *'a) Is the conduct that led to the charge easily remediable?*
> *b) Has it in fact been remedied?*
> *c) Is it highly unlikely to be repeated?'*

The panel was of the view that while the misconduct in relation to your poor record-keeping may be more easily remediable, your decision-making that led to the other instances of misconduct, as influenced by your own personal views, may be more difficult to remedy. In particular, the panel considered that your misconduct in relation to your failure to maintain professional boundaries and comply with instructions not to contact a patient may be more difficult to remediate. It was of the view, however, that such conduct is capable of being remedied.

The panel then considered whether the misconduct identified has been remedied. In relation to your failure to record important information in patient records and your failure to comply with instructions not to contact a patient, the panel noted the absence of any

evidence from you of strengthened practice in respect of these failings. In particular, it noted that there is no evidence before it of any training, insight, or remorse on your part in relation to your poor record keeping. Further, it noted that whilst you provided an explanation for why you failed to comply with an instruction not to contact a patient, you have not expressed any remorse for the distress this may have caused them, and you have not provided any evidence of insight or reflection. The panel therefore determined that your misconduct, in relation to your poor record-keeping and your failure to comply with instructions not to contact a patient, has not yet been remedied. On the evidence before it, therefore, the panel cannot be satisfied at this time that such misconduct is highly unlikely to be repeated in the future.

The panel next considered your misconduct in relation to your failure to follow instructions and not visit a patient. It was of the view that you have not yet shown sufficient insight into your actions of attending at Patient D's house due to concern for their dog and for leaving a message on their phone. The panel could not, therefore, be satisfied at this time that your misconduct in relation to your failure to follow instructions was highly unlikely to be repeated in the future.

The panel next considered your misconduct in relation to breaching professional boundaries. It acknowledged that you have taken significant steps to remedy this aspect of your misconduct. It noted that you have provided evidence of training in relation to professional boundaries; you have expressed genuine remorse for your actions, and you have demonstrated good insight into how your actions may have affected Patient A and why you may have acted in the way you did. Additionally, the panel noted that you have [PRIVATE].

The panel also took into account that following the last breach of professional boundaries you continued to work as a registered nurse for a further period of three years without any further breaches of professional boundaries occurring. Taking all of this into account, the panel was satisfied that you have strengthened your practice sufficiently and that your misconduct in relation to the breaches of professional boundaries have been remedied.

The panel was satisfied that it is highly unlikely that this area of your misconduct would be repeated in the future.

The panel was of the view, however, that in relation to your failure to work cooperatively with colleagues, in particular your poor record keeping, and your failure to act upon instructions not to contact a patient, there is a risk of repetition in the future. This is based upon the fact that there is insufficient evidence before the panel of insight and strengthened practice in relation to these areas of your misconduct. The panel therefore decided that a finding of current impairment is necessary on the grounds of public protection.

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

The panel was of the view that you did not uphold fundamental professional standards of nursing and, as a result, public confidence in the professions, and the NMC as regulator, would be undermined if a finding of current impairment were not made. It, therefore, found that your fitness to practise is also currently impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired by reason of your misconduct on both public protection and public interest grounds in relation to charges 5, 7, 9, 14a, 14b and 15f.

It did not, however, find current impairment in respect of your misconduct in relation to charges 15e, 15g and 16 on the grounds of public protection or public interest. The panel determined that you have sufficiently strengthened your practice, demonstrated good insight and remorse, in respect of charges 15e, 15g and 16. Also in relation to charges 15e,15g and 16, the panel determined that, a finding of impairment is not required on the

ground of public interest. The panel whilst acknowledging its findings in respect of misconduct, further took into account that Children's Services and other authorities were informed and involved in your decision to be Patient A's birthing partner and look after her children at your house. In these circumstances, the panel was of the view that public trust and confidence in the profession and the NMC would not be undermined by the panel's decision that you are not currently impaired in relation to charges 15e, 15g and 16.

In relation to charges 5, 7, 9, 14a, 14b and 15f, having regard to all of the above, the panel was satisfied that due to your limited insight and lack of strengthened practice, you cannot currently practise kindly, safely and professionally and your fitness to practise is impaired, on the grounds of public protection and public interest.

Sanction

The panel has considered this case and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

You were informed in the original Notice of Hearing, dated 11 December 2023, that the NMC had advised you that it would seek the imposition of a 12-month suspension order with a review if it found your fitness to practise currently impaired. Mr Segovia submitted that the NMC considers that a 12-month suspension order with a review remains the proportionate and appropriate sanction in this case.

Mr Segovia referred to the panel's decision and reasons on impairment. Mr Segovia noted that in relation to charges 5, 7, 9, 14a,14b and 15f, the panel found that limbs a, b and c of the *Grant* test were engaged and that your fitness to practise is currently impaired on the grounds of public protection and public interest. Mr Segovia highlighted that the panel

found that there was a risk of repetition in relation to your record keeping and your failure to follow instructions regarding not contacting Patient D.

Mr Segovia invited the panel to consider the following aggravating features in relation to your conduct:

- Lack of insight
- Abuse of position of trust
- Conduct which put patients at risk of harm

Mr Segovia submitted that your failings regarding your record keeping could have been addressed by a conditions of practice order if you had demonstrated sufficient insight. However, Mr Segovia noted that the panel found that you have not provided any evidence of any training, insight or remorse in relation to your record keeping failings.

Mr Segovia submitted that your failure to follow instructions regarding not contacting Patient D, cannot be addressed by a conditions of practice order as your conduct may be indicative of an attitudinal issue. Further you have not expressed remorse or any insight in relation to your failure to follow instructions regarding not contacting Patient D and any subsequent harm that may have been caused to Patient D.

Mr Segovia submitted that, in relation to charges 5, 7, 9, 14a, 14b and 15f, a conditions of practice order would not address the public protection and public interest concerns identified given your lack of remediation, insight and remorse. Mr Segovia therefore submitted that a suspension order, for a period of 12 months with review, is the appropriate and proportionate order in this case.

Mr Hussain-Dupre stated that you have had difficulty understanding the case against you and reconciling this with your own experience.

Mr Hussain-Dupre submitted that, in respect of charges 5, 7, 9, 14a and 14b, the panel found that although there was a risk of harm, no actual identifiable harm was caused.

Mr Hussain-Dupre submitted that your record keeping errors were only subsequently identified after a retrospective audit was undertaken. He submitted that, in relation to charges 14a and 14b, you made a call and visited Patient D's home on the instigation of social services. He submitted that you were the duty nurse and attempted to contact the manager and other staff at the time, however no one else was available. Mr Hussain-Dupre submitted that your conduct in relation to charge 15f was in line with the discussions you had had with social services.

Mr Hussain-Dupre submitted that these failings occurred during an 8-month period in an otherwise unblemished 40-year career. He submitted that you had no complaints raised regarding your practice for 37 years, prior to these incidents. He submitted that you have had no restrictions on your practice and subsequently practised for a period of 3 years without further complaint. Mr Hussain-Dupre referred the panel to the positive references and testimonials provided.

Mr Hussain-Dupre submitted that the panel must consider proportionality when deciding what sanction, if any, to impose. He submitted that you should be allowed the opportunity to demonstrate your insight moving forward.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

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

The panel took into account the following aggravating features:

- Lack of insight into failings
- Conduct which put patients at risk of suffering harm

The panel also took into account the following mitigating features:

- Your previously unblemished 37-year career before the conduct arose
- Your unblemished 3-year career since the conduct arose

The panel had regard to the contextual circumstances of your case. The panel noted that you were employed as a mental health agency nurse for 8-months by the Trust when the concerns arose. The panel took into account that, during this period of your employment with the Trust, COVID-19 restrictions were in place, you were provided with limited induction, and in practice support appeared to be very limited. This resulted in a difficult working environment for you. Additionally, the panel noted that in relation to your record keeping failings, you were only made aware of these failings when your line manager undertook a retrospective audit of your record keeping. No formal concerns, regarding your record keeping, were raised with you at the relevant time whilst you were under supervision.

The panel considered the seriousness of your conduct. The panel had regard to the NMC guidance titled *'How we determine seriousness'*, reference *'FTP-3'* last updated 27 February 2024.

> *'Some behaviours are particularly serious as they suggest there may be a risk to people receiving care; examples include:*

- *conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care,*
- *sexual misconduct,*
- *discrimination and harassment, and*
- *misconduct otherwise involving cruelty, exploitation or predatory behaviour, such as abuse or neglect of children and/or vulnerable adults.'*

The panel determined that your case does not fall into any of the categories as outlined in the guidance above and is therefore not a case where your conduct is *'particularly serious'.*

The panel next considered, what sanction, if any, to impose. The panel bore in mind its duty to impose the least restrictive sanction which sufficiently protects the public and addresses the public interest.

The panel considered whether to take no action but concluded that this would not be appropriate nor proportionate. The panel decided that it would not sufficiently protect the public nor address the public interest concerns identified.

It then considered the imposition of a caution order but again determined that, due to the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified, in that you have not demonstrated sufficient remediation, insight or remorse in the outstanding areas of regulatory concern. Further the panel decided that a caution order would not be proportionate given the public protection and the public interest concerns previously identified.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case and would sufficiently protect the public and address the public interest concerns previously identified.

The panel had regard to the fact that these incidents happened over 3 years ago and that, other than these incidents, you have had an unblemished career of 37 years as a registered nurse. Further you practised as a registered nurse for 3 years, after these incidents occurred, with no further concerns having been raised. The panel noted that there is no evidence before it of harmful deep-seated personality or attitudinal problems. The panel was of the view that your failings in relation to your record keeping and failure to follow instructions can be addressed through assessment and/or retraining.

The panel determined that conditions could be formulated which are relevant, proportionate, workable and measurable that will sufficiently protect the public and mitigate the public interest concerns identified. Additionally, the panel was of the view that

it was in the public interest that, with appropriate safeguards, you should be able to practise as a registered nurse.

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

The panel therefore determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate and would not be a reasonable response in the circumstances of your case. The panel has found that there are clear contextual issues arising in this case. There is no evidence of harmful deep-seated personality or attitudinal problems. The panel determined that the areas of concern can be remediated. The panel therefore wish to afford you an opportunity to address these concerns.

The panel took into account that charges 5, 7, 9, 14a, 14b and 15f relate to two discrete areas of your practice, which are remediable with sufficient insight, remorse and strengthening of practice. The panel took into account that a conditions of practice order would allow you the opportunity to demonstrate sufficient insight, remorse and strengthening of practice in these areas.

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

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

1. You must ensure that you are supervised by a registered nurse any time you are working, in the following areas:
    a) Record keeping, specifically in relation to:
        i. Patient plans and formulations
        ii. Communication with patients and multidisciplinary teams
    b) Undertaking tasks in line with instructions

    Your supervision must consist of working at all times on the same shift as, but not always directly observed by, a registered nurse until signed off as competent by a more senior registered nurse. You must provide evidence of having been successfully signed off as competent to your NMC case officer within 7 days of completion.

2. You must meet monthly with your line manager/supervisor to discuss your progress and performance regarding:
    a) Record keeping, specifically:
        i. Patient plans and formulations
        ii. Communication with patients and multidisciplinary teams
    b) Undertaking tasks in line with instructions

    Until signed off as competent by your line manager/supervisor. You must provide evidence of having been successfully signed off as competent to your NMC case officer within 7 days of completion.

3. You must obtain a report from your line manager/supervisor in relation to your progress and performance regarding:
    a) Record keeping, specifically:
        i. Patient plans and formulations
        ii. Communication with patients and multidisciplinary teams
    b) Undertaking tasks in line with instructions

    You must send this report to your NMC case officer 14 days prior to the next review hearing.

4. You must keep a personal development log in relation to your progress and performance regarding:
    a) Record keeping, specifically:
        i. Patient plans and formulations
        ii. Communication with patients and multidisciplinary teams
    b) Undertaking tasks in line with instructions

    You must send your NMC case officer a copy of the log 14 days prior to the next review hearing.

5. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within 7 days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

6. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within 7 days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

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

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

The period of this order is for a period of 12 months in order to allow you time to demonstrate sufficient remorse, insight and strengthening of practice in the outstanding areas of regulatory concern.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may extend the order or vary any condition of it, or it may replace the order for another order. You have the opportunity to ask for an early review if you have complied with all conditions in the order and/or have taken effective steps to address the problems in your practice which led to the order being imposed.

Any future panel reviewing this case would be assisted by:

- Your engagement with the NMC and attendance at the next review hearing
- An up-to-date reflection demonstrating your insight into the outstanding areas of regulatory concern
- Evidence of any strengthening of your practice, including any relevant training, in the outstanding areas of regulatory concern

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Segovia. He highlighted that the panel has determined that there are outstanding public protection and public interest concerns. He therefore invited the panel to impose an interim conditions of practice order on the same terms as the substantive order for a period of 18 months. He submitted that this interim conditions of practice order will cover any period of an appeal.

The panel also took into account the submissions of Mr Hussain-Dupre. He submitted that there is no objection to the NMC's application for an interim conditions of practice order.

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 nature of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months in order to cover any period of appeal.

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

That concludes this determination.