Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 10 – Friday 14 January 2022

Virtual Hearing

Name of Registrant:	**Julie Elizabeth Borek**
NMC PIN:	82C0261E
Part(s) of the register:	Registered Nurse (1984) Health Visitor (1989)
Area of registered address:	Wiltshire
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair, lay member) Sandra Lamb (Registrant member) Susan Laycock (Lay member)
Legal Assessor:	Angela Hughes/Michael Hosford Tanner
Hearings Coordinator:	Jamila Bernard-Stevenson
Nursing and Midwifery Council:	Represented by Sapandeep Maini-Thompson
Julie Elizabeth Borek:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7, 8a, 9, 10
Facts not proved:	Charge 8b
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Borek was not in attendance and that the Notice of Hearing letter had been sent to Ms Borek's registered email address on 29 November 2021.

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

The panel accepted the advice of the legal assessor.

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

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

The panel noted that the Rules do not require delivery and that it is the responsibility of any Registrant to maintain an effective and up-to-date registered address.

Decision and reasons on proceeding in the absence of Ms Borek

The panel next considered whether it should proceed in the absence of Ms Borek. It had regard to Rule 21 and heard the submissions of Mr Maini-Thompson who invited the panel to continue in the absence of Ms Borek. He submitted that Ms Borek had voluntarily absented herself and had indicated an unwillingness to participate in the proceedings.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Ms Borek;
- Ms Borek has sent correspondence to the NMC dated 23 December 2021 which indicates that she is not engaging and will not attend the hearing
- Ms Borek retired from nursing on 31 August 2018
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness has attended today to give live evidence, others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2017 and 2018
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Borek in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made a limited response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give

evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Borek's decisions to absent herself from the hearing, waive her right to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charges

That you, a registered nurse, employed as a health visitor by Wiltshire Children Community Services:

Between 1 January 2017 and 31 August 2018

1) In relation to child A:

    a) Failed to escalate a potential domestic abuse concern [**PROVED**]
    b) Did not make contact with the child's mother [**PROVED**]
    c) Did not record adequate notes [**PROVED**]
    d) Did not visit the child as required [**PROVED**]

2) In relation to child B:

    a) Failed to escalate a domestic abuse concern [**PROVED**]
    b) Did not contact the child's mother [**PROVED**]
    c) Did not visit the child monthly [**PROVED**]

3) In relation to child C:

a) Did not monitor the health and development of the child of the family [**PROVED**]
b) Did not have sufficient oversight of the child's care [**PROVED**]
c) Allowed a school nurse to deputise at Core Group meetings [**PROVED**]

4) In relation to child D:

a) Did not see the family and/or child as required [**PROVED**]
b) Did not escalate concerns [**PROVED**]
c) Did not make notes that were sufficiently detailed [**PROVED**]

5) In relation to Child E:

a) Did not keep adequate notes [**PROVED**]
b) Did not follow up a cancelled CIN meeting [**PROVED**]

6) In relation to Child F:

a) Did not follow up Child F's mother's low mood symptoms [**PROVED**]
b) Did not keep and/or make detailed notes [**PROVED**]

7) In relation to Child G:

a) Did not adequately assess the Child [**PROVED**]
b) Did not make adequate notes [**PROVED**]

8) In relation to Child H:

a) Did not make face to face contact with child as required [**PROVED**]
b) Did not document meeting on 16 February 2018 adequately [**NOT PROVED**]

9) Did not contact some and / or all children on CPP's every 4 weeks [**PROVED**]

10) Did not follow national pathways when assessing children and / or families [**PROVED**]

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

Background

The charges arose from alleged events which took place whilst Ms Borek was employed as a Band 6 Health Visitor for Wiltshire Children Community Service (Virgin Care). At this time, Ms Borek was employed on a permanent contract which entailed working approximately 30 hours per week. In this role, she was responsible for a caseload of approximately 350 children. These children were categorised according to the extent of intervention that they required. Children that required a partnership approach to complex issues were categorised as Universal Partnership Plus ('UPP'). Children who required a rapid response from the health visiting team when specific additional expert help is required were categorised as Universal Plus ('UP'). These children could be further categorised if they had other needs such as: -

Children subject to a Child Protection Plan

A Child Protection Plan is a plan drawn up at case conferences by the local authority and multi-agency partners. This plan sets out the child's needs and the areas that need to be addressed in order for the child to be safe and supported in their environment.

Child In Need ('CIN')

A Child in Need is a child who is under the age of 18 and requires local authority intervention in order to maintain a reasonable standard of health and/or development and/or to prevent significant further harm to the child.

Looked After Child ('LAC').

A Looked After Child is a child that has been in the care of the local authority for a period of more than 24 hours. Looked after children are classified as potential high risk.

Some children were also categorised as Team Around the Child ('TAC'). These cases involved children who were categorised as either UPP or UP. Children within this category were subject to a Common Assessment Framework ('CAF') which was a plan drawn up in order to address a child's unmet needs.

Frequency of visits and meetings

As part of her role, Ms Borek was expected to undertake visits. The nature and frequency of these visits was determined by the Caseload Prioritising System and categorisation of the child.

At the material time, the Caseload Prioritising System stated that it was a minimum requirement for a health visitor to undertake visits at four weekly intervals for Children who are categorised as Universal Partnership Plus and are further categorised as being subject to a Child Protection Plan.

At this time, health visitors were also expected to undertake bi-monthly home visits and (if the child was of pre-school age) to attend core group meetings. It was a requirement of the role that health visitors attended all necessary visits. It was not considered adequate for a school nurse to replace a health visitor in these circumstances.

Health visitors were also required to attend Child in Need meetings. These meetings were scheduled to take place by the allocated Social Worker at four to six weekly intervals.

It was also a minimum requirement that health visitors review Child in Need cases within their allocation every four to six weeks.

Irrespective of the categorisation of the case, the health visitor was also expected to escalate domestic abuse concerns in a timely and proactive manner.

Recording requirements

Ms Borek was required to keep a comprehensive record of the information she obtained during her visits and meetings. Between 1988 and 2017, Ms Borek was expected to record this information manually, however, from January 2018, she was expected to record this information on a digital case management system called 'System One'.

It was a requirement of the role that all entries were made in a timely and accurate manner.

Performance Concerns

A complaint was received in July 2018 from a Wiltshire Safeguarding Chairperson at Wiltshire Council. This complaint was that Ms Borek had failed to visit Child A (who was subject to a Child Protection Plan) at her home. As a result of receiving this complaint, an internal investigation was conducted.

Further concerns were identified following an initial review of Ms Borek's caseload by the investigating officer (Witness 1). This led to a review of care provided to all her priority cases. This found concerns in relation to the care provided by Ms Borek to another seven children (Children B to H).

A disciplinary hearing took place on 30th August 2018 and Ms Borek was subsequently dismissed from her employment.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Maini-Thompson on behalf of the NMC. The panel also had regard to Wiltshire County Council and Virgin Care guidance including: - f y Child Programme guidance and the Case

Prioritising guidance. It also had sight of Ms Borek's written response to the local disciplinary hearing which was held on 30 August 2018, as well as her responses during the local investigation meeting held on 9 July 2018.

The panel has drawn no adverse inference from the non-attendance of Ms Borek. The panel considered the written response provided by Ms Borek, however, it noted that her account could not be tested by cross-examination and that this affected the weight that the panel attached to her written evidence.

The panel accepted the legal advice provided by the legal assessor.

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

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

- Witness 1: Public Health Team Leader and Health Visitor- Virgin Care

- Witness 2: Public Health Team Leader- Virgin Care

The panel considered the witness and documentary evidence provided by the NMC and Ms Borek (namely her written response to the disciplinary investigation).

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

Charge 1a

1) In relation to child A:

    a) Failed to escalate a potential domestic abuse concern

This charge is found proved

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 1.

Child A was under a Child Protection Plan. On 5 March 2018, a police notification was received ('PPD1') regarding domestic abuse involving Child A's mother.

Witness 1 explained that Ms Borek failed to properly identify and escalate this concern. In this situation, she told the panel that Ms Borek should have contacted Child A's mother as soon as possible by phone. She should also have escalated the concern to Child A's social worker.

In her witness statement she said:

> '*"the Registrant failed to properly identify and escalate a potential domestic abuse concern in respect of Child A. It is documented from March 2018 that there was a heightening risk of domestic abuse. There was no evidence that the Registrant made contact with the mother (Victim) when she was presented with the information and instead added it to be discussed at an upcoming group meeting. …The Registrant should have made contact with the mother as soon as possible by telephone. The Registrant failed to take a proactive approach to an issue that potentially placed Child A in danger. The Registrant should have known to escalate and handle this concern because the Caseload Prioritising System states UPP families include ''families open to Multi-agency Risk and Assessment Committee (''MARAC") or PPD1 where concerns persist''. A PPD1 is a police report concerning incidents of domestic violence."*

The panel could find no evidence that Ms Borek had escalated the concerns regarding domestic violence and therefore found charge 1a proved.

Charge 1b

b) Did not make contact with the child's mother

This charge is found proved

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 1. It also had regard to the Healthy Child Programme which states that a review assessment is needed in relation to safety and wellbeing, including domestic abuse. Witness 1 explained to the panel that this assessment should be holistic and involve the family circumstances as they would impact on the child's wellbeing. The panel also took account of her witness statement as detailed in charge 1a. The panel could find no evidence within Child A's notes that Ms Borek had made contact with the mother following the PPD1. Therefore, the panel found charge 1b proved.

Charge 1c

c) Did not record adequate notes

This charge is found proved.

The panel took into account the witness statements and oral evidence of Witness 1 and Witness 2. Both were able to explain to the panel the minimum information required to detail a substantive holistic assessment of the child.

Witness 1 told the panel that she would expect to see:-

- A chronology of significant events
- The purpose of the contact
- Who was present
- What was observed
- A detailed overview or picture of the child's daily life
- Analysis of the observations
- A plan for future contact and/or referrals

In her written statement, Witness 1 said:

> *"The Registrant's notes for Child A are not as detailed as I would expect them to be. . .if the Registrant failed to document things there is no proof that anything was discussed, what the outcomes or plan following the meeting were, or who was present."*

The panel accepted Witness 1's evidence and could see no evidence of the required records in Child A's notes. The panel therefore found charge 1c proved.

Charge 1d

d) Did not visit the child as required

This charge is found proved.

The panel considered the witness statement and oral evidence of Witness 1. In Witness 1's witness statement, she stated that as Child A was subject to a Child Protection Plan, Ms Borek was required to visit her at four weekly intervals and to visit her at home on a bi-monthly basis.

Witness 1 said in her witness statement:

> "*The CPP stated that ''[Child A's] general health and development to be monitored'' for the duration of the plan and the Registrant was responsible for doing this. The Registrant failed to see [Child A] within the four week timeframe for part of the*

period of the plan and whilst domestic abuse events were occurring within the family. This failure is serious as a reassessment of his emotional and developmental needs, and an assessment of any new risks to his health and well-being at the time the family circumstances were deteriorating would have been indicated, and that the guidelines for seeing children on a CPP was not adhered to."

The panel also considered the admission made by Ms Borek in her written response to the disciplinary investigation that she did not see Child A between 26 March 2018 and 25 May 2018.

Therefore, the panel found this charge proved.

Charge 2a

2) In relation to child B:

   a) Failed to escalate a domestic abuse concern

This charge is found proved.

In reaching this decision, the panel considered the witness statement and oral evidence of Witness 1.

The panel noted that Child B was on a CPP. In her witness statement, Witness 1 stated that on 9 January 2018, there was a police report pertaining to domestic abuse and that on 10 January 2018, Child B attended a minor injuries unit at a hospital with a finger injury. Witness 1 explained that although Ms Borek documented that she would discuss this matter at a Child in Need meeting on 22 January 2018, this was an inadequate response. In her oral evidence, Witness 1 told the panel that because Child B was on a CPP that Ms Borek should have escalated any report of domestic abuse to the social worker.

Witness 1 said in her witness statement:

"The Registrant documented that she would discuss the domestic abuse issue on 22 January 2018 at the next CIN meeting. The Registrant failed to take a proactive approach to an issue that potentially placed the child in danger…."

The panel could find no record of any appropriate escalation and therefore found this charge proved.

Charge 2b

b) Did not contact the child's mother

\This charge is found proved

In reaching this decision, the panel considered the witness statement and oral evidence of Witness 1. Witness 1 gave evidence that as Child B was subject to a Child Protection Plan and a police report had been made, Ms Borek would have been expected to contact Child B's mother within a few days of being notified of the police report.

Witness 1 said in her witness statement:

"*The Registrant would have been expected to make contact with the mother as soon as possible by phone and not to wait 12 days to bring it up at a meeting which was then cancelled. I do not think this ended up being discussed at all in the end.*

…

The CIN meeting due on 22 January 2018 did not take place until 31 January 2018. Child B's mother was not present at the meeting."

The panel could find no evidence that contact was made in an acceptable timeframe with Child B's mother and therefore found this charged proved.

Charge 2c

c) Did not visit the child monthly

This charge is found proved

The panel considered the witness statement and oral evidence of Witness 1. The panel also considered Ms Borek's written response to the disciplinary investigation.

In her written and oral evidence, Witness 1 stated that as Child B was subject to a Child Protection Plan, Ms Borek was expected to visit Child B every four weeks.

The panel noted that Ms Borek had stated in her written response to the disciplinary investigation that Child B had been assigned an outreach worker from the children's centre and a family support worker from Social Care. Ms Borek also stated that as Child B was attending nursery three days per week ''little role for health visitor except in advising about diet and constipation.''

Witness 1 was asked whether in such circumstances, Ms Borek would no longer be expected to undertake regular visits to Child B. She told the panel that no matter which other agencies were involved in a child's care, the health visitor still had to follow the requirements of the Caseload Prioritising System for a child on a CPP.

The panel could find no evidence of the required visits and/or assessment being carried out and therefore found charge 2c proved.

Charge 3

3) In relation to child C:

a) Did not monitor the health and development of the child of the family

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1 who stated that Child C was subject to a Child Protection Plan and that as a result of this Ms Borek was expected to visit Child C every four weeks. Witness 1 gave evidence that Child C was assessed by Ms Borek on 2 February 2018. However, she told the panel that this assessment was of limited depth and failed to provide a full health assessment of Child C. At this assessment, it was noted that Child C would require a referral to a speech and language therapist. There is no evidence that this referral was sent until May 2018.

Witness 1 said in her witness statement:

> "*The Registrant did not engage sufficiently with Child C. Child C should have been seen by the Registrant on a four weekly basis. Instead the school nurse attended and led all contact with Child C. The Registrant allowed the school nurse to take a main role in Child C's care plan. This is something the Registrant should have known was within her requirements as a health visitor and beyond the professional expectations of the school nurse. This was a serious failing as the health visitor did not monitor health and development of the child on a CPP plan as per the usual expectations of the role, and therefore this could have put the child at risk."*

The panel could see no evidence that Ms Borek had carried out the required monitoring and assessments for Child C and therefore found charge 3a proved.

Charge 3b

b) Did not have sufficient oversight of the child's care

This charge is found proved.

The panel considered the oral and written evidence of Witness 1 and Ms Borek's written response to the disciplinary investigation. In her written response, Ms Borek stated that she had a limited role in this case as the case was only allocated to her on 31 January

2018. Ms Borek further stated that her role was also limited because Child C was in nursery three days per week and attended a children's centre every Friday. In her oral evidence, Witness 1 told the panel that the fact that other stakeholders were involved in a child's care did not mean that Ms Borek was no longer under an obligation to follow the requirements of the Caseload Prioritising System and the CPP.

The panel could find no evidence that Ms Borek had any face to face contact with Child C after February 2018, as would have been expected under the guidelines for a child on a CPP. Therefore, the panel found charge 3b proved.

Charge 3c

c) Allowed a school nurse to deputise at Core Group meetings

This charge is found proved.

In reaching this decision, the panel considered the oral and written evidence of Witness 1 and the accompanying exhibits. The panel noted that according to the case notes, a school nurse attended some of the Core Group meetings in this case instead of Ms Borek. In her oral evidence Witness 1 told the panel that this was not acceptable as Child C was under the age of 5 and the school nurses do not have appropriate training in the assessment of pre-school children.

Witness 1 said in her witness statement:

> ''*Health visitors should always be a key professional present at the meetings and visits. While health visitors might cover for school nurses, if a school nurse is unable to attend a meeting or visit, this should not happen in the reverse. School nurses are not the appropriate people to deal with the development of children less than five years of age…"*

The panel could see from Child C's notes that the school nurse attended several of the Core Group meetings in place of Ms Borek. The panel therefore found charge 3c proved.

Charge 4a

4) In relation to child D:

a) Did not see the family and/or child as required

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1 and the Ms Borek's written response to the disciplinary investigation. Witness 1 gave evidence that as the child was categorised as a Child in Need, Ms Borek was required to visit the child at four to six weekly intervals. The panel considered extracts from Ms Borek's case notes which showed that she had not visited Child D after December 2017. The panel considered Ms Borek's comments in her written response that (after being informed by Child D's social worker that the case would be closed) she decided to treat Child D as if he had been categorised as a universal case. The panel noted that there is no entry on System One which corroborates either this conversation or the alleged change in categorisation of the case.

In her witness statement, Witness 1 said:

> ''*The Registrant would have known from the Caseload Prioritising system that she was required to complete regular reviews every four to six weeks. While the Registrant made many attempts to access Child D's home and conduct home visits, the Registrant failed to engage the family in order to see Child D for at least a six-month period. The Registrant attempted to gain access to Child D's residence on 25 April 2018 but was unable to. On the same day, the Registrant documented that she noticed a lot of mess outside of the family residence. At this point, I would have expected the Registrant to escalate concerns to the Child's Social worker. The relevant Did Not Attend Protocol is attached…''*

The panel could not find any evidence that Ms Borek had seen the family and/or Child D as would have been expected under the Caseload Prioritising system and therefore finds charge 4a proved.

Charge 4b

b) Did not escalate concerns

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1 and Ms Borek's written response to the disciplinary investigation. The panel noted that Child D's case notes indicate that numerous attempts were made by Ms Borek to visit the child between 20 April and 19 June but that these attempts were unsuccessful as she was unable to gain access to the property. The panel noted that on her attempted visit on 25 April 2018 Ms Borek recorded that there was a bag of rubbish and a dirty towel left outside of Child D's mother's property which had been there since her last visit. Witness 1 told the panel that such a situation could be indicative of increasing mental health concerns regarding Child D's mother with a consequent risk of neglect. She told the panel that in these circumstances she would have expected Ms Borek to raise a concern but that Ms Borek appeared to have taken no further action. The panel noted that in Ms Borek's written response to the disciplinary investigation, she acknowledged that it was her responsibility to escalate any concerns, however, she believed that this had already been done by a support worker.

Witness 1 said in her statement:

> "*…health visitors are the key professionals who would be well placed to identify and escalate any concerns. As the Registrant did not see Child D for more than six months and failed to gain access to the family residence on several occasions, the Registrant failed to escalate her concerns and do all she could to ensure the safety of Child D…''*

The panel also had regard to the Did Not Attend protocol which provides guidance on steps to be taken and escalation measures in the event of recurrent lack of access.

The panel was unable to find any evidence that Ms Borek had escalated concerns to the social worker and therefore found charge 4b proved.

Charge 4c

c) Did not make notes that were sufficiently detailed

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1. In her evidence, Witness 1 stated that her overall impression was that Ms Borek's record keeping was lacking. Witness 1 further stated that in Child D's notes Ms Borek failed to provide details about future plans in relation to Child D's case.

In Witness 1's statement she said:

> ''*The Registrant's record keeping on this case was poor and lacked the detail that would be expected, in particular an analysis of risk factors."*

In Ms Borek's evidence to the disciplinary hearing:

> ''*…The visit on 08/12 also included [Person 1]. He said that social care were closing the case, I understood there to be no further CP concerns and treated the child as universal."*

The panel could find no evidence in Child D's notes to substantiate the discussion with the social worker, if indeed that discussion took place. The panel therefore accepted Witness 1's evidence that Child D remained on a CPP. The panel considered that this was evidence that Ms Borek's notes in this case was not sufficiently detailed. The panel therefore found charge 4c proved.

Charge 5a

5) In relation to child E:

a) Did not keep adequate notes

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1. In her evidence, Witness 1 stated that Child E was categorised as a Child in Need following their sibling disclosing to their schoolteacher in May 2018 that they were scared to go home. Witness 1 told the panel that Ms Borek was required to visit Child E once the case has been allocated to her and was also required to undertake follow-up visits every four to six weeks. Witness 1 further stated that there was no evidence that this had taken place.

In her Witness statement:

> *"The Registrant failed to keep adequate notes and carry out visits every four to six weeks as required for children on CIN plans… Following a cancelled CIN meeting the Registrant did not follow up with the social worker whether a meeting had been rescheduled. . . this was a failure on the Registrant's part, as the guidance for children on a CIN plan is that a reassessment of the child/family's needs by the Health visitor takes place within the given time frame, and this was breached, which was serious as it could have placed the child at risk."*

The panel were unable to find evidence of any entries in Child E's System one notes suggesting that Ms Borek had ever assessed the child. The panel therefore found charge 5a proved.

Charge 5b

b) Did not follow up a cancelled CIN meeting

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1 and extracts from Ms Borek's notes. The panel noted that a Child in Need meeting scheduled for 4 July 2018 had been cancelled and that following this cancellation there was no record of Ms Borek making enquiries regarding whether the meeting would be re-scheduled. Witness 1 gave evidence that it was Ms Borek responsibility to do this.

The panel could find no evidence that Ms Borek had made any attempt to follow up the cancelled CIN meeting and therefore found charge 5b proved.

Charge 6a

6) In relation to Child F:

a) Did not follow up Child F's mothers low mood symptoms

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1. In her evidence, Witness 1 stated that there was evidence in Ms Borek's notes for the Team Around the Child meeting at Child F's home on 10 January 2018 that she was aware of the mother of Child F's low mood. She told the panel that in this situation, Ms Borek would be expected to make a detailed assessment of the effects of the mother's mental health on the family situation but that Ms Borek failed to do this.

Witness 1 said in her statement:

'' … Child F's mother suffered from a low mood and as such the situation required monitoring. In this case there is no evidence of robust record keeping or adequate

assessment of the family situation. . . . The Registrant failed to follow up on the mother's low mood or record that the family's situation had been reassessed as per guidance for UPP families. This was a failure because low mood was having an impact on the child and the family, including living conditions, which could have deteriorated further and put the child at risk of neglect."

The panel noted that there is an entry in Ms Borek's case notes for 10 January 2018 pertaining to Child F which states that the mother has a low mood and is not motivated to do anything. The panel also noted that there were no further entries pertaining to this matter.

The panel therefore could find no evidence that Ms Borek had followed up on Child F's mother's low mood symptoms and therefore found charge 6a proved.

Charge 6b

b) Did not keep and / or make detailed notes

This charge is found proved.

In reaching this decision, the panel considered Witness 1's evidence and Ms Borek's notes. Witness 1 told the panel that Ms Borek attended three TAC meetings on 10 January 10 January 2018, 7 March 2018 and 9 May 2018, however, her notes consisted of generalised remarks and lacked the specific information which a proactive assessment required.

The panel noted from the System One records that the records of these visits did not contain the level of detail which both Witness 1 and 2 had previously told the panel would be expected. The panel therefore found charge 6b proved.

Charge 7a

7) In relation to child G:

a) Did not adequately assess the child

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1 who told the panel that Child G was subject to CAF intervention due to developmental delays and was classed as a UP case. Child G was the sibling of Child F.

In her witness statement, Witness 1 stated that Ms Borek was not nominated as the 'lead professional' for the case. In her oral evidence, Witness 1 acknowledged that there was some evidence of assessment(s) being undertaken. However, these assessments were inconsistent and were not holistic. Witness 1 noted that Ms Borek recorded that the child had speech delay at the TAC meeting on 10 January 2018 but that she did not make a speech and language referral until May 2018 after the child's Ages and Stages questionnaire on 16 May 2018.

In Witness 1's statement she said:

> *''Child G was subject to CAF intervention because of developmental delays. Child G was classed as a UP case. … There is no evidence of assessment or robust record keeping. The Registrant's notes lacked detail of who was present at the TAC meetings one what was discussed during the meetings on 10 January 2018, 7 May 2018 and 9 May 2018. The Registrant's record keeping fell below the expected standard. . .*
>
> *The Registrant was not nominated as the lead professional in this case: however she still failed to comply with the requirements of the Caseload Prioritising policy.''*

The panel accepted Witness 1's evidence that Ms Borek did not adequately assess Child G and therefore found charge 7a proved.

Charge 7b

b) Did not make adequate notes

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1. In her statement she said:

'' In this case there was a failure to follow record keeping standards, so that there is not a full picture of the child's progress or evidence of reassessment over a six month period despite him being on a CAF plan. This is a failure by the Registrant as it could possibly have led to delay in care being provided and poorer outcomes for the child.''

In Ms Borek's statement in the disciplinary investigation:

''It was agreed with the family and lead professional and school that TAC meetings every 8 weeks were sufficient as concerns were reducing.''

The panel accepted Witness 1's evidence that the notes for Child G were inadequate when referring to the standards already described by Witness 1 and 2. The panel could find no evidence to substantiate Ms Borek's statement and determined that if such an agreement had been made then the panel would have expected it to have been recorded so that all members of the multidisciplinary team were aware of the alleged deviation from the normal requirements. The panel therefore found charge 7b proved.

Charge 8a

8) In relation to child H:

a) Did not make face to face contact with the child as required

This charge is found proved

In reaching this decision, the panel considered the evidence of Witness 1, who told the panel that Child H was transferred to the Chippenham locality within the Wiltshire Public Health Nursing Team from a neighbouring locality. Child H was a Looked After Child meaning that she had been placed in foster care.

In Witness 1's statement she said:

> *''As Child H was a looked after child in foster care she would be classed as a potentially high risk individual. The Registrant made very few efforts to document any support provided by her to Child H or the foster parents. Child H was a vulnerable child and her health and wellbeing needs should have been assessed within the given timeframe. The Carer's need for support and advice could also have been addressed sooner. This led to a delay in care and support being given, which is a serious failing on the Registrant's part.''*

The panel noted from Child H's records that the initial assessment required within a few days of a child being transferred into the area was carried out by another health professional on 7 February 2018. The panel accepted Witness 1's evidence that a transferred in child in foster care is automatically classified as UPP according to the Healthy Child Programme and therefore should have face to face contact with the health visitor every four weeks. However, Ms Borek's first record of any meeting with Child H was recorded on 8 May 2018.

The panel noted from Ms Borek's statement in the disciplinary investigation that she states that she visited Child H on 8 March 2018 and completed a LAC health assessment but there is no evidence for this on the System One notes before the panel.

The panel was unable to find any evidence that Ms Borek had made face to face contact with Child H as required for a UPP Looked After Child and therefore found charge 8a proved.

Charge 8b

b) Did not document a meeting on 16 February 2018 adequately

This charge is found not proved

In reaching this decision, the panel considered the evidence of Witness 1 who told the panel that there was an administrative entry was made on Child H's notes on 16 February 2018. In her statement Witness 1 said:

''There is an administrative entry on 16 February 2018 documenting an updated telephone number. The first meeting that the Registrant recorded in relation to Child H was recorded on 8 May 2018. It is not clear where this took place, what was discussed and who was present at the meeting. There is no evidence of observations or assessments.''

The panel noted that there is an entry on Child H's notes for 14 February 2018 amending a mobile telephone number. There is a further entry on 16 February 2018 stating ''no notes were originally recorded. LAC Health Assessment done at carer's home. no concerns identified and LAC HA forms sent to . . .safeguarding admin.''
The panel could not be certain from the evidence whether an actual meeting took place on 16 February 2018 and therefore Ms Borek had an obligation to record a meeting on this date.

Therefore, the panel on the evidence before it found that NMC had not discharged its burden of proof in relation to charge 8b and therefore found it not proved.

Charge 9

9) Did not contact some and / or all children on CPP's every 4 weeks

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1. She said in her witness statement :

'' I found that for most of the cases, the Registrant had conducted home visits within acceptable time scales as defined within the Healthy Child Programme. However, there were eight cases where the time limits since the last contact had been exceeded. The Registrant had not carried out home visits on these cases four weekly (as per UPP service on Healthy Child Programme) and failed to escalate concerns to line management, or the Safeguarding or Social Care teams, where these contacts had not been maintained. . .

Children on CPPs should receive contact every four weeks. The Registrant did not achieve this across any of the cases where children were placed on CPPS. … The Registrant's requirements to hit these targets would have been clearly identified on each child's care plan. It would be reasonably expected of that a nurse working as a health visitor with equivalent experience to the Registrant would have been aware of the requirement, The Registrant would have been able to consult the Caseload Prioritising System … for assistance on how to identify her objectives for such cases.''

The panel accepted Witness 1's evidence in this regard and noted its previous findings in relation to children A, B and C. Further, it noted Witness 1's evidence where she refers to

Ms Borek not achieving contacts with any of the children who had been placed on CPPs. As she had had the opportunity to examine all of the notes of the children on Ms Borek's caseload the panel accepted her evidence as accurate. Therefore, it found charge 9 proved.

Charge 10

10) Did not follow national pathways when assessing children and / or families.

This charge is found proved.

The panel accepts that this charge relates solely to the children on Ms Borek's caseload who were categorised as UP/UPP.

In reaching this decision, the panel considered the evidence of Witness 1. She said in her statement:

> *'' The Registrant failed to follow local and national pathways for assessment and reassessment of all the children listed as being UP or UPP on her caseload. The Registrant would have known from her Safeguarding Training that Safeguarding information was available on the Wiltshire Council website, and on Virgin Care Safeguarding policies available on the intranet. The Registrant failed to act on the concerns she did identify and document. This placed the relevant children on her caseload as potential risk."*

The panel accepted Witness 1's evidence in this regard and noted its previous findings in relation to children A-H. Therefore, it finds this charged proved in relation to all eight children in the relevant category.

Fitness to practice

Submissions on misconduct and impairment

Mr Maini-Thompson moved on to the issue of misconduct and impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Maini-Thompson submitted that Ms Borek's had breached Rule 10.1, 10.2 and 10.3 and 13.1, 13.2 and 13.4 of the Nursing and Midwifery Council's Code of Conduct 2015.

Breach of rule 10

Mr Maini-Thompson submitted that Ms Borek had breached Rule 10.1, 10.2 and 10.3 of the Nursing and Midwifery Council's Code of Conduct 2015 in respect of her conduct in the cases of Child A, Child D, Child E, Child F, Child G and Child H. Rule 10 imposes a duty on Registrants to keep clear and accurate records which are relevant to a Registrant's practice. Mr Maini-Thompson further submitted that during the course of Ms Borek's employment as a health visitor, she failed on multiple occasions to adequately note the content of meetings, make health visits and escalate matters to the relevant authorities when required.

Breach of Rule 13

Mr Maini-Thompson submitted that Ms Borek had breached Rule 13.1, 13.2 and 13.4 of the Nursing and Midwifery Council's Code of Conduct 2015 in respect of her conduct in the cases of Children A to H. This rule 13 imposes the duty on Registrants to recognise and work within the limits of their competence. Mr Maini-Thompson further submitted that during the course of Ms Borek's employment as a health visitor, she failed to assess children and their family members, she failed to make health visits and to escalate matters to the relevant authorities when required.

In closing, Mr Maini-Thompson submitted that Ms Borek's misconduct was aggravated by the fact that she made repeated failures over an extended period (namely between 1

January 2017 and 31 August 2018). He also noted that there was an absence of any evidence of remediation from Ms Borek and that this factor increased the risk of repetition.

Mr Maini-Thompson noted Ms Borek's mitigating factors but submitted that: - i) Ms Borek's difficulties transitioning to a digital case management system and ii) Ms Borek's experience [PRIVATE] did not adequately explain her repeated failure to meet the standards expected of her within the role.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, Calheam v General Medical Council [2007] EWHC 2606 (Admin) and Johnson, Maggs v Nursing and Midwifery Council [2013] EWHC 2140 (Admin) and CHRE v Nursing and Midwifery Council and Grant [2015] EWHC 927 (Admin).

Decision and reasons on misconduct

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

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

> ***1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> *1.4. make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

8 Work cooperatively

To achieve this, you must:

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, and

10 Keep clear and accurate records relevant to your practice

This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.

To achieve this, you must:

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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

To achieve this, you must:

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

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information, and

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the facts found proved amounted to misconduct because the misconduct included consistent failings which occurred over a sustained period. The panel found that the cumulative effect of this was that Ms Borek failed to fulfil her duty to vulnerable children and their families. The panel noted that Ms Borek failed to ask for assistance with her caseload. The panel determined that owing to these factors there was a high likelihood of repetition.

The panel found that Ms Borek's actions did fall seriously short of the conduct and standards expected of a nurse and/or health visitor and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

d) *. . . . . .*

The panel finds that children were put at risk and were potentially at risk of harm or neglect as a result of Ms Borek's misconduct. The panel finds that Ms Borek's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel finds that the first three limbs of Grant were engaged in this case.

Regarding insight, the panel considered that Ms Borek had attended three one to one interviews with Witness 2 and an appraisal meeting during the period that performance concerns had been raised. In addition to this, Ms Borek also had regular contact with Witness 2. The panel noted that during these meetings Ms Borek raised concerns pertaining to her experiences [PRIVATE] but failed to proactively seek support for addressing any of the performance concerns which were raised. While Ms Borek asked to reduce her working hours and asked for more time to carry out her practice teacher role, at no time did she indicate to Witness 2 that she was unable to fulfil the requirements of her caseload. The panel determined that during these meetings Ms Borek showed a lack of insight into her failings and the potential implications of these failings on vulnerable families.

The panel was satisfied that the misconduct in this case could potentially have been remedied but it found that Ms Borek's lack of insight, attitudinal issues and negativity towards the new ways of working meant that the panel could have no confidence that Ms Borek was able or willing to remedy her shortcomings.

The panel is of the view that there is a risk of repetition based on the fact that there were a number of incidences of misconduct over a sustained period of time. Furthermore, Ms Borek states that she has retired from the profession and therefore she has not had the opportunity to remediate. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that a finding of impairment was necessary to protect the public because Ms Borek's misconduct exposed Children A to H to significant risk of serious harm.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made because serious performance concerns have been identified, Ms Borek has failed to remediate and there is a high likelihood of repetition. Therefore, in this case the panel finds Ms Borek's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Borek off the register. The effect of this order is that the NMC register will show that Ms Borek has been struck-off the register.
In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Maini-Thompson submitted that the NMC would seek a suspension order, pending remediation and reflection on the part of Ms Borek.

Mr Maini-Thompson further submitted that a suspension order is necessary to maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This is because Ms Borek failed to remediate and because there is a high likelihood of repetition.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put families and children at risk of suffering harm.

The panel also took into account the following mitigating features:

- Ms Borek's personal mitigation that: - Ms Borek encountered difficulties in dealing with new technologies [PRIVATE]. However, the panel found that these mitigating factors are outweighed by the potential risk of harm caused to children A to H as a result of Ms Borek's failings.

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

It then considered the imposition of a caution order but again determined that, due to the potential risk of harm caused to children A to H and the likelihood of repetition that had been identified, an order that does not restrict Ms Borek's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Borek's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Borek's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the fact that Ms Borek has retired and has disengaged from the fitness to practise process.

Furthermore, the panel concluded that the placing of conditions on Ms Borek's registration would not adequately address her attitudinal issues and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel considered the SG as to circumstances when a suspension order may be the appropriate sanction:-

- a single instance of misconduct but where a lesser sanction is not sufficient
- no evidence of harmful deep-seated personality or attitudinal problems
- no evidence of repetition of behaviour since the incident
- the Committee is satisfied that the nurse midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour

The panel has already determined that this was not a single incident but a pattern of misconduct over a considerable period of time. The panel has also identified attitudinal problems in Ms Borek's response to her line manager and in the course of the disciplinary investigation as well as her approach to the changes in working practices. Furthermore, the panel has also found that Ms Borek does not have insight into her failings and there is a risk of her repeating those failings should she be allowed to return to practice unrestricted. While it accepts that there has been no repetition of the behaviour it notes that Ms Borek has not worked since she was dismissed from her position in August 2018.

Therefore, in this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Ms Borek's misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel was of the view that the serious breaches of fundamental tenets of the profession evidenced by Ms Borek's actions are fundamentally incompatible with Ms Borek remaining on the register.

Furthermore, the panel was of the view that the findings in this particular case demonstrate that Ms Borek's misconduct was so serious that to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In making this decision, the panel carefully considered the submissions of Mr Maini-Thompson in relation to the sanction that the NMC was seeking in this case. The panel carefully considered imposing a suspension order but for the reasons above, found that there were no key features in this case which indicated that it was suitable for such a sanction. The panel also noted Ms Borek's non-engagement with the fitness to practise proceedings and her previous applications for voluntary removal from the register. The panel also noted that Ms Borek retired from practice in August 2018 and has not worked as a Registered nurse since.

The panel considered that a striking off order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse and/or health visitor.

Decision and reasons on interim order

Mr Maini-Thompson submitted that given that the panel had imposed a substantive order, an interim order was required to cover the appeal period. He submitted that an interim order of suspension for a period of 18 months would be appropriate given the sanction imposed by the panel.

The panel accepted the advice of the legal assessor.

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

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

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

That concludes this determination.