Strictly Private and Confidential

REPORT OF PROFESSIONAL CONDUCT COMMITTEE FOLLOWING AN INQUIRY HELD PURSUANT TO SECTION 58 OF THE HEALTH AND SOCIAL CARE PROFESSIONALS ACT 2005 ("THE ACT ")

Name of Registrant:	**Niamh Fehily**
Registrant in Attendance:	**Yes**
Registration Board:	**Physiotherapists** Registration Board
Registration No:	**PT037324**
Registered Address:	[redacted]
Case Number:	**C357**
Date(s) of Inquiry:	Day 1 - **27 March 2025** Day 2 - **09 May 2025** Day 3 - **22 July 2025**
Members of Inquiry Committee:	**Geraldine Feeney** – Chair **Nicola McLaughlin** – Registered Physiotherapist Professional Member **Brain Melaugh** – Registered Social Worker Professional Member
Legal Assessor:	**Patricia Dillon SC**
Appearances:	
For the Registrar:	**Eoghan O'Sullivan BL** **Hannah Unger** of FieldFisher Solicitors
For the Registrant:	**Martin Canney BL** **Tara Nolan** of Kent Carty Solicitors

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The Nature of the Complaint that resulted in the Inquiry:

The allegations to be considered at the Inquiry are that you, being a registered Physiotherapist, employed by Spectrum Health, Gandon House, Amien Street, North Wall, Dublin 1;

1. On one or more dates between on or around 02 August, 2022 and on or around 26 October, 2022;

(a) Failed to afford appropriate treatment to our patient, [redacted] and/or

(b) Failed to refer [redacted] for further diagnostic investigation; and/or

(c) Failed to maintain accurate and/or adequate records; and/or

2. Such further allegations as may be notified to you in advance of the Inquiry.

3. AND FURTHER TAKE NOTICE that the act(s), omission(s) or pattern(s) of conduct at one or more allegations at 1 – 2 above amount individually and/or in combination and/or cumulatively to act(s), omission(s) or pattern(s) of conduct that constitute a failure by you to meet the standards of competence that may reasonably be expected of a registered Physiotherapist and thereby constitute poor professional performance.

4. AND FURTHER TAKE NOTICE that it is alleged that the act(s) and/or omission(s) and/or pattern(s) of conduct at one or more of allegations 1 – 2 above, amount individually and/or in combination and/or cumulatively to act(s), and/or omission(s) and/or pattern(s) of conduct that constitute a breach or breaches of the following Sections of the Physiotherapist Registration Board Code of Professional Conduct and Ethics, adopted by the Physiotherapist Registration Board (contained in the Schedule to the Code of Professional Conduct and Ethics for Physiotherapists By-law 2019 (S.I. No. 45 of 291) which came into effect on 28 February, 2019.

5. 18 – **Keep accurate records**

   You must:-

   (a) Keep clear and accurate and up to date records in line with the policies and procedures set out in your workplace or as dictated by relevant Guidelines or legislation.

   (b) Make sure that all records are:-

   - Complete.
   - Legible (if handwritten).
   - Identifiable as being made by you, using your registered name and Registration Number.

- Dated and timed.
- Completed as soon as practicable following assessment.
- Intervention or treatment; and
- Clear and factual.

Evidence presented to the Committee

Attached find Transcripts (three of the Inquiry)

The Committed heard evidence from the following witnesses on behalf of the CEO:-

Day 1 – 27 March, 2025

- [redacted]
- Ms. Tara Hanlon – Expert/CEO

Day 2

- Ms. Tara Hanlon continued – Expert/CEO

The Committee heard evidence from the following witnesses on behalf of the Registrant.

Day 2

- Ms. Niamh Fehily – the Registrant

Day 3

- Professor Kieran O'Sullivan – Expert on behalf of the Registrant.

Documentary Exhibits

1. The Core Book.
2. Exhibit 2 – Statement of the Registrant, Ms. Niamh Fehily.
3. Exhibit 3 – Expert Report of Professor O'Sullivan on behalf of the Registrant.
4. Exhibit 4 – Book of physiotherapy exercises.

5. Exhibit 5 – Appendices attached to the Registrant's statement at Exhibit 2.

Preliminary applications

There were no preliminary applications.

Decision of the Committee:

Background to the complaint

1. [redacted] "*the Complainant*" was an enthusiastic runner who, in 2019, was diagnosed with oestrogen positive breast cancer. This was treated by surgery followed by chemotherapy and radiation. This treatment finished in mid-February of 2020, when the Complainant returned to training. In October, 2021, she tore her quadricep muscle running in a marathon and attended Ms. Niamh Fehilly, "*the Registrant*" with that injury in 2021. Following breast reconstruction surgery in May of 2022, the Complainant returned again to running on 21st June, 2022.

2. The Complainant told the Committee that she used a Garmin device which monitored sleep, steps, activity and these could be posted to an app called [redacted] and the user could also input personal information to Strava. These are described as the [redacted] [redacted] and these records are described by the Complainant as contemporaneous records. They were generated by her using her Garmin device and these records include the period when the Complainant was attending the Registrant between 2nd August, 2022 and 26th October, 2022.

3. There is no issue but that the Complainant attended the Registrant on 2nd August, 2022, 5th September, 2022, 12th September, 2022, 19th September, 2022, 13 October, 2022, 20th October, 2022 and 26th October, 2022, in connection with various complaints of decreasing running tolerance and increasing pain, according to the Complainant, and of various complaints connected with running and without any significant pain, according to the Registrant.

4. On 7th November, 2022, the Complainant attended with a different Physiotherapist with a history of decreased running and increasing hip flexor/gluteal pain. This Physiotherapist noted her prior history and requested an urgent MRI to rule out stress factor of femur due to level of pain, medical history and tamoxifen. The record of this physiotherapy review was admitted in evidence before the Committee. An MRI performed in December, 2022, indicated atypical finding suggestive of Mets. Thereafter the Complainant in December, 2022, had confirmed to her a diagnosis of cancer spread to her bones. There is no allegation that any treatment afforded to the Complainant caused/contributed to these ultimate findings.

5. Following the above, the Complainant made a complaint to Spectrum Health about her treatment by the Registrant. Following receipt of same, Spectrum Health carried out an investigation during which the Registrant was requested/directed to update/complete her physiotherapy notes referencing the treatment provided by her to the Complainant. The Registrant updated her records on 16th February, 2023.

6. The Committee were provided with three sets of records:-

(a) The original records made by the Registrant in relation to each of the above dated attendances by the Complainant with her ("*the original records"*).

(b) The same records updated by the Registrant on 16th February, 2023, from her own recollection of the appointments ("*the updated records")*.

(c) The Complainant operated a Garmin device which recorded information was connected to an app called [redacted] which recorded mileage including cycling and also notes inputted contemporaneously by the Complainant (the "[redacted] *records"*).

7. The Committee notes that the Registrant updated the records of four consultations, namely, 2nd August, 2022, 13 October, 2022, 20 October, 2022 and 26th October, 2022. These alterations/updating consisted of adding material/information and, in one instance, removing material/information already in the records.

8. The Committee notes that insofar as Allegation 1(c) is concerned, the Registrant accepts and admits that she failed to maintain adequate or accurate records. It is further admitted by the Registrant that this constitutes poor professional performance, but not professional misconduct.

Allegation 1(a)

That you, being a registered Physiotherapist, employed by Spectrum Health, Gandon House, Amiens Street, North Wall, Dublin 1:-

1. On one of more dates between on or around 2 August, 2022, and on or around 26 October, 2022:-

   (a) Failed to afford appropriate treatment to your patient, [redacted].

This allegation was proven as to fact beyond reasonable doubt.

Allegation 1(b)

(b) Failed to refer [redacted] for further diagnostic investigations.

This allegation was proven as to fact beyond reasonable doubt.

Allegation 1(a) and Allegation 1(b) were proven as to fact beyond reasonable doubt.

Reasons:

1. Whilst Allegation 1(a) and Allegation 1(b) are separate and distinct allegations, the underlying factual matrix is the same, namely, the Complainant's attendances with the Registrant in her professional capacity as a Physiotherapist in mid/late 2022.

2. Insofar as the three sets of records are concerned, the Committee is satisfied that the most reliable records are those that are contemporaneous, that is the "[redacted] *records"* as entered

by the Complainant and the "*original records"* as entered by the Registrant. The Committee notes that these are contemporaneous records. Whilst the original records of the Registrant of the consultations of 2 August, 13, 20 and 26 October, 2022 were sparse particularly insofar as the October entries are concerned, they are nonetheless proximate to the events. The Committee notes that the "*updated records"* were made by the Registrant in February, 2023, some 3½ months after the stated consultations. The Registrant attributed her almost total recollection of these consultations in October to the fact that this was the only complaint made against her. The complaint in question was not notified to the Registrant until January, 2023, and up to that point in time she had no reason to reconsider these consultations. The Committee are satisfied that if the Registrant had had any reason to reflect upon her interactions with the Complainant prior to February, 2023, she should have updated/completed the original notes long in advance of being requested to do so by her employer. In the opinion of the Committee, the updated records are unreliable because:

(i) The lack of any contemporaneous note or record by the Registrant other than the "*original record"*. The Registrant herself admits that her "*updated records"* include information suggesting the Complainant told her that she no longer had pain and her symptoms had settled. The Registrant accepted this was critically important information not recorded in the "*original notes*". The "*updated records"* are not consistent with the picture that emerges from a consideration of the original notes and the [redacted] records, both of which were either proximate or contemporaneous with the events;

(ii) The sheer unlikelihood of an ability on the part of any person to remember the minutiae and detail inserted by the Registrant in the "*updated records"*;

(iii) The effect of the passage of time on memory generally;

(iv) The absence of highly relevant information not included in the original records but included in the updated records;

(v) The prior knowledge of the Registrant of the complaint against her prior to making the updated records;

(vi) The number and variety of clients who attended the Registrant in the intervening period between October, 2022 and February, 2023;

(vii) The contemporaneous [redacted] records, in general, do not corroborate the updated records but substantially corroborate the original records;

3. The Committee found the Complainant to be an honest, truthful and credible witness who was doing her best to assist the Committee. She openly admitted that she could not recollect certain complaints or what was discussed at the physiotherapy sessions even when the contents of the physiotherapy note/record was read out to her. Where she could recollect, she confirmed her position to the Committee and she accepted from the beginning that the pain in question had moved before it ultimately settled in or around her glute. It seems to the Committee that the Registrant qualified, in her oral evidence, certain of the contents of her original records to support a narrative of improvement in the Complainant's condition which was not recorded in the original notes. The Complainant was not improving as outlined to the Committee by Ms. Hanlon in her evidence. The entries made in the updated notes are self-serving and seek to uphold the decision-making and narrative of the Registrant. For the reasons already set out, the Committee have decided it would be unsafe to rely upon the updated notes. Overall, the Committee prefers the evidence of the Complainant acknowledging as she does the gaps in her memory to that

of the Registrant who has provided updated records in meticulous detail and a recollection of events on which the Committee finds are not recorded in the contemporaneous and proximate notes.

Attendance – August 2, 2022

4. The Complainant attended the Registrant on August 2nd, 2022, with complaints relating to her left quad tightness and a shoulder complaint. She attended on 5th September, 2022 and 12th September, 2022, all of which entries were locked on 12 September, 2022. It is understood that once a record is locked it cannot thereafter be altered. It is noted that in the 2nd August, 2022 original record no reference was made to the prior history of cancer but in the updated record of 2nd August, 2022, as made by the Registrant on 15th February, 2023, the record reads "*previous history of breast cancer"*. The Registrant told the Committee that she made that addition because she was fully aware that the Complainant had a previous history of breast cancer. The Committee notes that the record of 2nd August, 2022, references reconstruction of right breast in May, 2022, but no history of cancer is recorded in any of the notes nor the fact that the Complainant was being treated by way of Tamoxifen, a continuing treatment for cancer. Such a significant medical history and treatment should be included as a matter of course. It was suggested to the Complainant that her Oncologist, [redacted] in June of 2022 had confirmed to her she did not have cancer and cleared her for running. The Complainant disagreed with this and told the Committee that the Oncologist could not guarantee she was cancer free and that "*they just hope all the treatment worked"*. The Registrant told the Committee that at the time when the Complainant was presenting and because she had got the all-clear from her Cancer Specialist "*that is why I didn't refer her for an MRI scan at the time"*. The Committee accepts that the Complainant was cleared to return to running in June of 2022, after her surgery. If the Registrant understood that the Complainant was free of cancer, that should have been recorded and so should the fact that she remained under active treatment with Tamoxifen. The Committee accepts the evidence of the Complainant in relation to the information provided to her by her Cancer Specialist. The Committee are of the opinion that if that information was provided, it should have been recorded in the notes and further, that the Complainant's medical history was a significant medical history and should also have been recorded.

Attendance - 19th September, 2022

5. The original notes made by the Registrant on 19th September, 2022, record "*Consent gain. Side lunges aggravating R knee P. Right hip flexor feeling tight t/o* (throughout) *the day when sitting and feeling this when running, began a few days ago"*. Under Objective, the Registrant set out the tests that she had carried out and what she found and described the Complainant as "*managing symptoms well"*. This consultation was locked on 21st September, 2022, by the Registrant. There are no updated records in relation to the 19th September, 2022.

6. The first [redacted] record of 19th September, 2022, made by the Complainant records "*third week in a row and seem to be falling apart more"*. The second [redacted] record of the same date records "*home from physio. Ache in quad is tight hip flexors"*. This [redacted] notes corroborates the Complainant's presentation in the original record made by the Registrant. In evidence the Registrant said that the right hip flexor was not the main complaint on the day and that it was not something that the Complainant was very much concerned about by any means. She further stated that the right hip flexor tightness was from running and poor biomechanics in running. She described the Complainant's presentation as "*slight tightness"*. The Committee notes that the complaint as recorded by the Registrant on the day was not qualified in any way. It was not recorded in the original notes that the cause of the issue related to running/biomechanics. The Committee noted the evidence of the CEO's expert, Ms. Hanlon, that the complaint made on this day was an escalation from the previous

attendances. Ms. Hanlon emphasised on a number of occasions that the significant issue in the entry of 19th September, 2022 (as made by the Registrant) was the feeling of tightness that was present when sitting as muscles do not hurt when sitting. The pertinent test is the quadrant test which was not recorded in the original notes. The Registrant disagreed with the expert and told the Committee that she herself had had hip flexor tightness and it occurs when sitting depending on one's position. The Committee prefers the expert evidence of Ms. Hanlon that it is very significant when considering a muscular matter that there is a complaint of tightness when sitting. The Committee accepts the evidence of the expert, Ms. Hanlon, that this presentation, i.e., "*right hip flexor feeling tight t/o the day when sitting"* might indicate there was some joint pain or joint component because that it is most likely to give one pain in the anterior thigh. Her opinion was that one would have to examine the hip joint to see why there was pain when sitting. There is no record of a hip joint being assessed although there was of calf tightness and back muscle tightness in the original records. Ms. Hanlon confirmed the profile of the symptoms had changed and there should have been a reassessment of the working diagnosis and test to ascertain why the earlier treatment was not working.

7. The Registrant further gave evidence to the Committee of the test she said she performed on 19th September, 2022, including the Fadir and Faber and set out what her usual practice was although these tests are not recorded in the original notes. The Committee noted the expert evidence of Ms. Hanlon that as a generalisation if the record does not record a test being carried out, she would assume it was not carried out. The Committee further notes that it was never put to the Complainant that the causative factor in relation to her pain was her running/biomechanics, nor indeed was that recorded in the original notes.

8. In the opinion of the Committee, the [redacted] *notes"* corroborate the Complainant's presentation as per the original record made by the Registrant. This was the first reference to right hip/flexor issues. The [redacted] record shows that the Complainant was (contrary to the Registrant's evidence) much concerned about her physical condition on 19th September, 2022, and the Committee is therefore satisfied that the Complainant was concerned about her physical condition as recorded by her in the contemporaneous [redacted] note. The expert, Ms. Hanlon, confirmed that the profile of symptoms had changed and that there should have been a reassessment of the working diagnosis and tests to ascertain why the earlier treatment was not working and why the symptoms were changing. The presentation recorded by the Registrant in the original record could not be clearer and was not qualified by the Registrant in the way she qualified the entry in the course of her evidence as outlined above. If the pain was "*small"* or *"little"*, that should have been recorded. The Committee considers the evidence of the Registrant sought to support an unrecorded diagnosis that the Complainant's issues were, in her opinion in September/October, 2022, attributable to running/biomechanics although not so recorded by her in the original notes of this consultation.

9. The Committee was told by the Complainant that she went on holidays [redacted] and did some running but had to stop and stretch due to pain before trying to resume running. She described the pain as located at the top of her leg in the quad/hip flexor side on the righthand side. Whilst in [redacted] she was using a foam roller. She also contracted Covid in [redacted] and was taking Ibuprofen in terms of Covid treatment.

Attendance – 13 October, 2022

10. The original record made by the Registrant on 13th October, 2022, records "*consent gained. Managing symptoms ok, has Covid 2 week ago which has set back progress slightly. Went for a run on Sunday for 60 mins. R hip flexor P during and afterwards"*. "*P*" in this context means pain. There were no other entries made.

11. The "*updated record"* for 13th October, 2022, reads:-

> "*Consent gained, managing symptoms ok, has had Covid 2 weeks ago which has set back progress slightly. Went for a run on Sunday for 60 mins. R hip flexor P during and afterwards however has settled now.*
>
> *Nil red flags, nil neuro symptoms,*
>
> ***Objective***
>
> *SL SQ//NAD BL*
> SL Hop//nil P
> SL calf raise ¾ range w/ache
> L calf tightness
> BL QL and ES tightness
> LSP ROM//full t/o w awareness BL rot w flex at ER
> Hip ROM full t/o nil P
> Resisted R hip flex 4/5 with ache
>
> **Treatment**
>
> R/view ex's, discussed run program and pain management
>
> **Analysis**
>
> R hip flexor strain flare-up post 60 min run
>
> **Plan**
>
> R/V in 2/3/52

12. The [redacted] record of the same date recorded "*hip flexor and quad pretty painful now cycling as well."* The second [redacted] record for October, 13th stated "*back from physio, issue now quads and glute, no running until walking pain free"*.

13. The [redacted] record corroborates what was recorded in the original record made by the Registrant. The updated entry recorded that pain had settled now. The second [redacted] record recorded that the Complainant was not to run until pain free while walking. This establishes that the Complainant had pain. The Committee is satisfied that the inclusion by the Registrant of the words "*however has settled now"* is not corroborated by either the [redacted] records or the original note. There is no dispute but that the Complainant was told to stop running. In her evidence, the Complainant did not agree her pain had settled by the time of the consultation on 13th October, 2022, she described the pain as being "*a solid pain"* and it was her recollection that she had been limping and was advised by the Registrant to take painkillers for 3 days in a row although she was already on Ibuprofen. She was limping because she was in pain. The Registrant denied that the Complainant ever limped or that she saw her limping. In her evidence the Registrant said she prescribed exercises for the hip flexor tightness and that she had a conversation about the training and the amount of training and the type of training. Whilst there was no record of any discussion of training in the original notes, there is reference to a discussion on run program in the updated notes. The original notes make no record of any concern on the part of the Registrant at the level of training being undertaken by the Complainant. Whilst the Registrant could not remember

the amount of time the Complainant said the pain came on during her run, she remembered the Complainant saying it came on and was gradually decreasing after the run. Her opinion was she had a strain following a run which was not recorded in the original notes.

14. It is clear to the Committee from the original record that the Complainant presented with right hip flexor tightness on 19th September, 2022, and when she presented on 13th October, 2022, she complained of pain in the same area. This is corroborated by the entries made by the Complainant in her [redacted] record of the day and the original record made by the Registrant. Notwithstanding the escalation, the Registrant did not refer the Complainant for any further diagnostic investigations. Further, it seems clear to the Committee that the continued diagnosis was of mechanical pain and there was a failure to change or reassess that diagnosis notwithstanding the continuing nature of the diagnosis and the failure of the Complainant to improve but rather to disimprove. By any objective standard, looking at the original notes the Complainant's condition had deteriorated between 19th September, 2022 and 13th October, 2022, by which date she had right hip flexor pain and pain walking. In the opinion of the Committee, it is likely that the Complainant had a limp which was not picked up by the Registrant. On this date there should have been a reassessment of the diagnosis of mechanical pain and the Complainant should have been referred for further diagnostic investigation. The Committee agrees with the expert evidence of Ms. Hanlon in this regard.

15. The Committee considers that the inclusion of the words "*however has settled now"* in relation to the right hip flexor pain as included by the Registrant in the updated notes is disquieting in the extreme. If it was the case that the pain had settled, that should have been recorded at the time as it was critically important information and is not supported by the [redacted] records or the evidence of the Complainant. The Committee considers that the entry "*has settled now"* would have been recorded on the day if that in fact had been told to the Registrant. The Committee considers this entry "*however has settled now"* is not supported by the collateral contemporaneous information. The Committee prefers the evidence of the Complainant which is supported by the contemporaneous documentation.

19th October, 2022

16. The [redacted] record for 19th October records "*ouch 2*2 minutes tester before the physio tomorrow, pretty painful and unfit, quad/glute pain nasty. Spent the last 2 days trying to ease ass by sitting on a tennis ball. Still recovering from poxy virus as wrecked."* The Complainant told the Committee she had tried running for 2 minutes and walking for 2 minutes on 19th October so she could report to the Physio how she was getting on and that it was sore.

20 October, 2022

17. The original record made by the Registrant for the attendance on 20th October, 2022, recorded "*consent gained, attempted 2 min on 2 min off yesterday. 3 days ago sat on small ball to self-release, Pful since and increase post run yesterday, nil neuro symptoms."* The headings "*Objective, Treatment, Analysis and Plan"* were blank without data. The updated notes record "*consent gained. Attempted 2 min on and 2 min off by 5 sets yesterday nil P. 3 days ago sat on small ball to self-release glutes. Pful since and increase post run yesterday, nil neuro symptoms nil red flags.*

Objective

OHsq//full range nil P, nil glute P.
SLsq//full range, nil p
SLhop//nil P.

SL calf raise ¾ range with ache at L calf. L calf tightness
LSPROM//full t/o nil P.
Hip ROM full t/o nil P.
Resisted hip flex plus 4/5 W awareness
Resisted hip abd plus 4/5 BL piriformis test//BL glute tightness

Treatment

MFRBL glutes as normal
PT reported decrease to symptoms
STN BL calf ms RV ex's and advised to continue as able
Advised not to push through pain

Analysis

R hip flexor strain resolving
BL calf and glute tightness

Plan

RV as required.

18. The first [redacted] record of 20 October, 2022, records "*pretty peed off, seems to be steadily getting worse, no running."*

19. The second [redacted] record of that date records "*cycling for now, nice as pain free, lovely evening, will try more of this dud watch returned."* The Committee notes there are six references to nil P. in relation to the exercises. Under Treatment, the following is recorded "*PT reported decrease to symptoms"*. In the amendment to the original record the word "*nil P."* is included by reference to the 2 min on and 2 min off test the Complainant had carried out on 19th October, 2022. It is clear to the Committee that the [redacted] record of 19th October, 2022, recorded the Complainant as being "*pretty painful*" as outlined above. The [redacted] record of 20th October records "*seems to be steadily getting worse, no running"*. It is clear to the Committee that the [redacted] record corroborate the original note and does not support the updated note either as to nil pain when carrying out the exercises the previous day, or that there was any evidence of right hip flexor strain resolving as included by the Registrant in the updated notes. Both record pain. The first [redacted] record recording that she seemed to be steadily getting worse was made on the way to physio.

20. In evidence, the Registrant qualified the pain as described by the Complainant. She confirmed that the Complainant did report pain in her glute but it was not severe and she pointed out a 3/10 score on a graph. There is no such note in the original record, i.e., the pain is not described as "*not severe"*. The updated record which records right hip flexor strain resolving was not recorded in the original note and the Complainant's own contemporaneous record was "*steadily getting worse"*. The Registrant agrees she advised no running, there is no reference to improvement in the Registrant's original record. She told the Committee the hip flexor symptoms had reduced significantly by this date. The Registrant stated the hip flexor was tight but had improved compared to the previous session, noting that no actual records in relation to same were taken at the time. She told the Committee her clinical assessment was the Complainant did not need a referral because she appeared to have mechanical pain and was improving. This is inconsistent with the record made by the Complainant after the physiotherapy session "*pretty peed off. Seem to be steadily getting worse, no running"*. The original note made by the Registrant and the

contemporaneous [redacted] record made by the Complainant are generally corroborative of each other but are not corroborated by the updated notes of February, 2023. The Committee is satisfied that the Complainant attended with a complaint of pain which increased in the 2 minute on/off runs carried out by her on 19th October, 2022.

21. The Complainant's view was that she seemed to be getting worse and the Committee note that the final entry of 20th October, 2022, on the [redacted] record, records "*cycling for now, nice as pain free"*. This shows she had not been pain free earlier. It is clear to the Committee that at this stage and indeed as of 13th October, 2022, the Registrant should have reassessed her diagnosis because the Complainant was not improving. If she was improving that should have been recorded in the original note. The Complainant herself satisfied that she was not improving. She told the Committee that she was routinely going to physio and when she started she was running well consistently with good mileage but now at 15 minutes she was in pain. She confirmed that at that time that she brought painkillers with her to the expo for the Dublin Marathon because she knew because she had to stand all day. She agreed that that evening she was cycling without pain as recorded by her. Again, the contemporaneous [redacted] records support the first entry made by the Registrant that the Complainant had pain and that had increased post the run on 19th October, 2022. The original record made by the Registrant did not record a report of a decrease in symptoms nor did it record nil pain on the attempted 2 minutes off. It in fact recorded an increase in pain post the run. The original record did not indicate that the strain was resolving. The picture is of a worsening situation and the Registrant ought to have recognised this.

26th October, 2022

22. The original record made by the Registrant on 26th October, 2022, states:-

    "*Consent gained. Managing symptoms overall. P reducing, walking feeling twinges"*.

    The headings Objective, Treatment, Analysis and Plan contain no data and are all blank.

23. The updated record of 26th October, 2022, reads:

    "*Consent gained. Managing symptoms overall. PT reports that P reducing. Nil neuro symptoms, nil red flag.*

    Objective

    SL SQ//NAD BL
    SL hop//nil P, power improving
    SL calf raise full range, nil P.
    BL calf tightness
    LSP ROM//full t/ow nil P.
    Hip ROM full t/o nil P resisted right hip flex 5/5 nil P.

    Treatment

    MFR BL glutes//pt reported decrease to symptoms
    STN BL calfms
    RV ex's and advised to cont as able
    Advised not to push through pain

Analysis

Managing symptoms well overall, graded return to running. Right hip flexor P resolving. RV as required

There are no [redacted] records for 26th October, 2022.

24. In evidence, the Complainant confirmed that she was not running and she was in pain and reported pain. She confirmed that she did attend the gym and did/attempted to do the exercises she was advised to do including squats and lunges, although the lunges caused her pain at one point. She told the Committee that there was no decrease in her symptoms and that the updated record "*managing symptoms well overall. Graded return to running. Right hip flexor pain resolving"* definitely did not accord with her recollection. She confirmed that she was definitely still in pain which had moved around and settled into her glute. She confirmed that on the last occasion (26th October, 2022) when she saw the Registrant, she did become upset.

25. The Registrant in evidence described the Complainant on 26th October, 2022, as being really pleased with how much cycling she had done that week and that she was excited to cycle beside her husband who was running a marathon. She described the Complainant as pleased and happy with the way the exercises were going in terms of hip flexor, bilateral gluteal tightness. She confirmed that the Complainant did have bilateral gluteal tightness but objectively, she was moving very well and she advised a Bulgarian split squat because it was a progression exercise. She described the Complainant as happy with the forward lunge which the Complainant did not like but which she (the Complainant) specifically told the Registrant was not painful. She advised her to continue with that. She confirmed to the Committee the Complainant did not report pain on 26th October, 2022. She stated that the Complainant had a feeling of tightness in her gluteal muscle but she did not report severe pain or any pain on 26th October, 2022.

26. The Committee notes that the original record made by the Registrant records "*P reducing, walking feeling twinges"*. That is a record of reducing pain, it is not a record of no pain. The Committee notes that the words "*walking, feeling twinges"* was deleted by the Registrant. The Registrant told the Committee this was because she was of the view that she had misspelled the word "*twinges"*, the word was spelt correctly in the notes. The Committee notes that only four comments were recorded by the Registrant in the original notes. It was a very important entry that a subsequent reader would see that the Complainant was feeling twinges when walking regardless of how the word twinges were spelled. In the opinion of the Committee this explanation in relation to spelling is simply not credible and the more likely explanation is that the words "*walking feeling twinges"* would conflict with the updated notes as prepared by the Registrant. The Committee considers that the removal of this entry from the records is disquieting in the extreme.

27. The Committee is satisfied that as and of 26th October, 2022, the situation could not have been clearer to the Registrant. The Complainant had been advised to stop running due to pain and she had not resumed running by 26th October and the original record does not contain any advice that she was fit to return to running, although the updated record does. As of 13th October, 2022, she had not been running apart from the two testers. She had presented with gluteal tightness on 19th September, 2022, and with pain on 13th October, 2022, including pain on walking. She presented on 20th October with pain. The Registrant did not refer the Complainant for further diagnostic investigation. In the opinion of the Committee the Registrant should have reassessed her own diagnoses and reconsidered

same. She did not and such a failure is a failure to afford the Complainant appropriate treatment. The presentation of the Complainant as recorded in the original notes and as recorded in the available [redacted] records and in her evidence consistently present a picture of deterioration. The Committee notes that no improvement was recorded by the Registrant in the relevant original notes save for the entry of "*P reducing, walking feeling twinges"*. The Complainant disputed there was any improvement to her symptoms. The Committee is satisfied that the entry "*walking feeling twinges"* is a record of a complaint of pain by the Complainant when she was walking. This is a significant deterioration. The Committee is satisfied that there was a failure on the part of the Registrant to afford appropriate treatment to the Complainant by reconsidering and reassessing her own diagnosis and there was a failure to refer her onwards for diagnostic treatment.

28. For completeness, the Committee notes the evidence of the Complainant that she attended at the gym, that she did use the cross-trainer and other equipment. The Complainant confirmed that she attended with a different Physiotherapist on 7th November, 2022, she confirmed the history that she gave Mr. O'Regan of the Iona Physiotherapy Clinic was accurate in that she had been getting back to running 5 days a week, up to 38 miles; that she got a small bit of hip flexor pain on the right and took a week and a half off, ran 4 then 6 miles on holidays and could feel it. It was very painful walking and standing but she went for a run anyway but it was not great. She told him she was limping on holidays and was still limping a bit. She confirmed that she had attended a Physio 3 weeks in row post-holiday and was told she had tight QL/glutes and was told to try painkillers for 3 days. Walking for a bus on 22 October was very sore. She confirmed that she had been doing sit to stand on advice from the Physiotherapist at the gym and worked on the cross-trainer and then had to use a hot water bottle on the bum. On 7th November, the pain was so bad she thought she might throw up. Mr. O'Regan took the view that he could not rule out a stress fracture and he wrote to the Complainant's GP and breast consultant. It is important to note that the Committee considers that the record of complaints provided by the Complainant to Mr. O'Regan largely corroborates her evidence and the [redacted] records. At that attendance, there was no reason for the Complainant to have invented a limp or her complaints of pain on walking and standing. She recorded her attendances at the gym and the use of the cross-trainer and she confirmed to the Committee and the Committee accepts that the recollection recorded by Mr. O'Regan in his physiotherapy notes is an accurate reflection of the information provided by the Complainant and her recollection of how events unfolded.

29. The Registrant confirmed in evidence that on 12th February, 2023, she was asked to complete the notes. She confirmed to the Committee she worked on average an 8 hour day with 30 minutes lunch break and she might see fourteen patients a day for 4 days a week. She could not provide the consistent number but confirmed she was very busy with back to back patients. By 14th February, 2023, she was seeing sixty odd patients a week approximately. She confirmed that she had a very good recall of her sessions and that she had no contemporaneous notes other than the original notes already described. She confirmed under cross-examination she did not remember every single detail of every single test and every consultation but she set out what her practice was and she described having a vivid recollection of the presentation of the Complainant and that she had a specific memory of being told about a pain and where it was without it being recorded contemporaneously. In other words, she had a memory of how severe the pain was or how long the person had been suffering without it being recorded by her. She told the Committee the reason her memory in relation to the Complainant was that it is the only complaint against her and it was at the forefront of her mind since it happened. The Committee notes she was first notified on 13th/14th February, 2023. She confirmed when she came to update the notes, she had no documentation available to her other than the notes already made, i.e., the original records.

30. The Committee did not find the Registrant to be a reliable witness. The Committee noted that on a number of occasions the Registrant sought to minimise the contents of the original records, as outlined above by the Committee. As already stated, the updated notes are inconsistent with her contemporaneous [redacted] records in the main with the Registrant's original records.

31. For all the foregoing reasons, the Committee are satisfied that Allegation 1(a) and 1(b) are proven as to fact and the Committee are satisfied that the Registrant failed to afford appropriate treatment to [redacted] from 13th October, 2022 to 26th October, 2022, and also failed to refer [redacted] for further diagnostic investigations from 13th October, 2022 to 26th October, 2022.

32. **Findings of poor professional performance**:-

The Committee was satisfied that Allegation 1(a) and 1(b) amount to poor professional performance beyond reasonable doubt.

Reasons:

(i) The Committee agrees with the expert evidence of Ms. Hanlon and Professor O'Sullivan that Allegation 1(a) and Allegation 1(b) if proven as to fact do not amount to professional misconduct but do amount to poor professional performance. The Committee noted the opinion of Professor O'Sullivan that Allegation 1(a) did not amount to professional misconduct (if proven as to fact) but did amount to poor professional performance. Professor O'Sullivan told the Committee that in terms of the finding, he agreed with the CEO's expert, Ms. Hanlon, that the failings captured in 1(a) amount to poor professional performance by reference to the consultations between the Complainant and the Registrant in October, 2022. Both opinions were that there should have been an increased index of suspicion because the Complainant was not getting better, the complaints were dealing with different parts of the body and focus of the pain shifted to the hip. Both opinions agree there ought to have been a re-evaluation of the nature of the treatment and consideration for a referral. It is accepted that Professor O'Sullivan made reference to a decision or judgment based on the balance of probabilities. On re-reading the transcript, it is not entirely clear to the Committee whether the decision on the balance of probabilities being referred to is the decision made by the Registrant or his own decision but in any event his ultimate judgment was that the failures in question amounted to poor professional performance. It is for the Committee to be satisfied beyond reasonable doubt whether or not proven conduct amounts to poor professional performance or not. The Committee is satisfied beyond reasonable doubt by the evidence of the CEO's expert, Ms. Margaret Hanlon, that Allegation 1(a) and Allegation 1(b) individually do amount to poor professional performance on the part of the Registrant. Whilst the Committee notes the opinions as expressed by Professor O'Sullivan outlined above, the Committee is satisfied to make its decision based upon the opinion of Ms. Margaret Hanlon.

(ii) The Committee notes that Ms. Hanlon gave evidence to the Committee that a Physiotherapist makes a working diagnosis and decides on an intervention and then retests after the intervention to see what effect it has had. If there is an improvement it indicates one is on the right track. If there is not an improvement one should go back and question the original hypothesis/diagnosis. The records were lacking in detail and failed to record precisely where the pain was and how long it lasted. Ms. Hanlon described the assessments throughout as inadequate and unchanging, i.e., not reacting to a changing situation. The treatment was also

unchanging even though the Complainant's condition was changing. Ms. Hanlon was of the view that there should have been a reassessment on 19th September, 2022, and then a reassessment on the next date to see if there was an improvement. Certainly, if there was not an improvement between 19th September and 13th October, there was a need for a reassessment. It was clear in her evidence that by 19th October, there should have been a reassessment and the failure was serious because the Complainant had a history of cancer and there was always a risk of secondaries. The Committee agrees with the expert analysis of Ms. Hanlon. The Committee is however satisfied that the index of suspicion did not really crystallise until 13th October, 2022, at which stage it should have been abundantly clear to the Registrant that the Complainant's condition was disimproving.

(iii) Insofar as Allegation 1(b) was concerned, Ms. Hanlon's expert evidence was that on 13th October, a real red flag was raised. She was of the view that there should have been a change in the course of action then to come up with a different working diagnosis but particularly after 13th October, when the Complainant had not improved, and a referral for a hip x-ray or an MRI or CT scan, all or either of them or medical investigations should have been considered by the Registrant. This was serious, again because the patient had a history of cancer. The Committee agrees with Ms. Hanlon's analysis and the rationale for same. The Committee understands from the totality of the evidence of Ms. Hanlon that the critical date on which the Registrant should have moved to refer the Complainant on was 13th October, 2022, and, as outlined above, the Committee agrees.

(iv) Allegation 1(a) and Allegation 1(b) individually do amount to poor professional performance on the part of the Registrant.

(v) Allegation 1(c) is that on one or more dates between on or around 2 August, 2022, and on or around 26 October, 2022, the Registrant failed to maintain accurate and/or adequate records. On Day 1 of the Inquiry it was admitted on behalf of the Registrant that this allegation was admitted as to fact and further was admitted that this constituted poor professional performance. Insofar as the original records made by the Registrant are concerned, the Committee has already noted that the Registrant has admitted that the notes are not adequate. In the opinion of Ms. Hanlon notes should be completed within 24 hours. She noted that the notes were completed after a complaint had been made and over 3 months later. She was of the opinion that there is non-compliance with the Code which amounts to professional misconduct.

(vi) The Committee noted the opinion of the CEO's expert, Ms. Margaret Hanlon, that the Registrant's record keeping was such in their accuracy and adequacy as to amount to professional misconduct. In her opinion, these records were not complete in that they were not completed until 3 months post the date in question. In her opinion, it could not be ignored that the notes were completed only after a complaint had been made. The Committee notes that the Code requires a Physiotherapist to keep accurate records and requires that the Physiotherapist must keep clear, accurate and up to date records in line with the policies and procedures in the workplace or as per relevant Guidelines or legislation. The Physiotherapist must make sure that all records are complete (this did not happen until 3 months post-accident) or legible (there is no issue) identifiable as being by the Physiotherapist (there is no issue); name an Registration Number (there is no issue); dated and timed (there is no issue); completed as soon as practicable following assessment, intervention or treatment (there is non-compliance by the Registrant); clear and factual (there is non-compliance).

(vii) The Committee are of the opinion that where a Health Professional fails to keep clear, accurate and up to date records which are complete and completed as soon as practicable following assessment, intervention or treatment, that such Health Professional must be aware that the keeping of accurate medical records is a matter of basic importance in the discharge of their functions. The Committee agrees with advices given that such records constitute a vital safeguard for the Medical Practitioner and the client in any situation where it may later become necessary to conduct any form of investigation. The Committee agrees that every Practitioner must be taken as knowing records may later be used for other purposes such as Inquiries like the current Inquiry. The Committee noted the evidence of Professor O'Sullivan that Allegation 1(c) amounted to both poor professional performance and professional misconduct. He went on to say that the original notes and the retrospective notes unhesitatingly fell very far short of what one would expect in terms of contemporaneous recording arising from the consultation. In the opinion of Ms. Hanlon, this failure amounts to professional misconduct because it amounts to a breach of the Code and in particular, By-Law 18 of the Physiotherapist Registration Board Guide of Professional Conduct and Ethics adopted by the Physiotherapist Registration Board (contained in the Schedule to the Code of Professional Conduct and Ethics for Physiotherapist By-Law, 2019 (S.I. No. 45 of 2019) (which came into force on 28th February, 2019) and is therefore professional misconduct.

(viii) The Committee is itself satisfied (although it has regard to both experts' opinions) that this is a significant failure on the part of the Registrant to comply with the relevant Code adopted by the Registration Board of her profession, physiotherapy. This case clearly demonstrates the fundamental importance of the professional requirement to keep appropriate, adequate and up to date notes. Had these notes been kept, as they ought to have been by the Registrant, reliable information would then have been available to the Committee.

(ix) The Committee finds that Allegation 1(a), (b) and (c) were proven as to fact for all the reasons set out above. The Committee are satisfied that Allegation 1(a) and 1(b) each individually amounts to poor professional performance for the reasons set out beyond reasonable doubt. The Committee is satisfied that Allegation 1(c) amounts to both poor professional performance and professional misconduct beyond reasonable doubt. The Committee is satisfied that it is a failure by the Registrant to meet the standards of competence that may reasonably be expected of a Physiotherapist practicing physiotherapy, not to complete in a full comprehensive and timely fashion her records of a consultation and is also a breach of the applicable Code as outlined above at paragraph (vi).

Have you consulted with your legal assessor	Yes

Recommendation as to sanction:-

Having regard to the findings made, the Committee respectfully recommend the following sanctions:-

1. Censure and the attachment of conditions to the Registrant's registration;

2. The attachment of a condition to the Registrant's registration that, prior to engaging in the practice of the Registrant's profession in the Republic of Ireland or in the European Union (whether in a paid or unpaid capacity) that the Registrant be supervised in line with an individualised learning plan at her place of work and the following conditions shall apply:

   (a) The Registrant to identify a supervisor (to be approved by CORU) in advance of the supervision. Such Supervisor to be at the level of a Senior Physiotherapist and be registered with CORU or with another regulatory body in the United Kingdom or European Union.

   (b) The Registrant shall provide evidence to CORU that she has informed her Supervisor of these conditions.

   (c) That the Registrant shall prepare a learning plan setting out objectives and competencies such as:-

      (i) Clinical note taking; and

      (ii) Clinical decision making and review;

      (iii) Accurately completing assessments and case histories;

      (iv) Keeping accurate and contemporaneous records;

      (v) Developing and implementing intervention plans;

      (vi) Providing appropriate feedback following assessments;

      (vii) Making adequate clinical diagnosis;

   (d) The period of supervision to be for 2 months.

   (e) The learning plan must be agreed with the Registrant's Supervisor in advance of commencing supervision.

   (f) The Supervisor shall provide a written report to CORU at the conclusion of the supervision period noting whether the competencies in the Registrant's learning plan have been met.

   (g) CORU shall review the written report from the Supervisor as expeditiously as possible and confirm to the Registrant no later than __ days that the Registrant has received a positive supervisory report.

   (h) The Registrant must comply with any supports the Supervisor deems appropriate to support the Registrant.

   (i) For the avoidance of doubt, the Registrant may undertake the supervision in a placement or setting outside of Ireland provided that the setting and supervision are in the United Kingdom or European Union and that the setting and Supervisor are approved by CORU.

Rationale:-

1. The Committee accepts that the primary purpose of sanction is to protect the public and not to punish the Registrant, although sanction may have a punitive effect. The public interest requires that the Committee must consider the protection of the public, upholding of professional standards and the maintenance of public confidence in the profession when it comes to consider the issue of sanction.

2. The Committee accepts that it must apply, as advised, the principles of proportionality in measuring these interests and in measuring the proven conduct against the range of sanctions permitted under the Health and Social Care Professionals Acts, 2005, as revised and amended, and in particular s.66. The Committee must have regard to the circumstances and context in which the conduct took place. The Committee must have regard to the findings it has made when it comes to the issue of sanctions, one finding of professional misconduct and three findings of poor professional performance. The Committee has found that the Registrant seriously failed to meet the standards of competence that may reasonably be expected of a Physiotherapist. The Committee also found that the admitted failure of the Registrant to maintain accurate or adequate records was a breach of the obligation to keep accurate records as required by the Code of Professional Conduct in Ethics adopted by the Physiotherapy Board. The Committee had regard to the submissions made on behalf of the Registrar and the submissions made on behalf of the Registrant. Further, the Committee had regard to the statement of the Registrant and in particular paragraphs 8, 24, 25, 26, 27, 28, 29, 30, 31, 32 and the relevant Exhibits attached to that statement. The Committee had regard to the Sanction Guidance notes approved by Counsel on 29th June, 2023, noting that same are not binding.

3. The Committee must consider mitigating factors and aggravating factors.

4. **Mitigating factors:**

    1. The Registrant made admissions as to fact and as to poor professional performance insofar as Allegation 1(c) was concerned.

    2. There has not been a previous complaint against the Registrant either in Ireland or in England.

    3. The Registrant apologised to the Registrar and the Complainant for her failure to comply with CORU Standards in terms of record keeping.

    4. The Registrant took steps to improve her skills to maintain "*optimal patient care"* and to ensure future documentation would meet the required legal and professional standard.

    5. She completed three specific courses related to record keeping as outlined at paragraph 29 of her statement and attached Certificates of Completion in relation to same.

    6. She completed CPD on red flags, malignancy, clinical reasoning and differential diagnosis as outlined at paragraph 31 of her statement, totalling 15 CPDs with Certificates of Completion provided.

7. She confirmed that she has been unable to work in Portugal, cannot join the Order of Physiotherapists there until this case has determined and she has as a result not been able to work as a Physiotherapist over the past 2 years in Portugal. This has caused financial issues.

8. She confirmed at paragraph 30 that she returned to Ireland and worked in a clinical setting on 4th February, 2025, where she saw five patients and the Clinic owner confirmed that her documentation met CORU standards. The Committee noted the letter from Ranelagh Physiotherapy Clinic at Appendix 4, and as referred to in the evidence.

9. Arising from this case, the Registrant has reflected upon the issues raised and the reports of Professor O'Sullivan and Margaret O'Hanlon, she notes "*it did not occur to me that the Complainant might have a recurrence of cancer so soon after she had been given the all clear"*. The Committee understands however from paragraph 32 that the Registrant acknowledges the underlying issue of cancer recurrence is now a matter that she is acutely aware of and going forward she will diligently keep patient medical conditions under review.

10. She acknowledges that completion/updating of the four sessions, 22nd August, 13th, 20th and 26th October, 2022, was a breach of her obligations.

11. The Committee had regard to the submissions by Mr. Canny B.L. and in particular to the short timeframe encompassing the 13th, 20th and 26th October, 2022. The Committee noted the Testimonials and References offered.

12. The implied acknowledgement at paragraph 32 of the statement that obligation of a Physiotherapist to keep a diagnosis under review and to make appropriate and necessary referrals. Whilst no admissions were made by the Registrant in relation to Allegation 1(a) and 1(b), the Committee does take account of what is stated at paragraph 32 in mitigation.

5. **Aggravating factors:-**

(a) The Committee consider that the updating of the notes were self-serving on the part of the Registrant as was her evidence to the Committee.

(b) *Insight:*

The Committee are of the view that there are deficiencies in the insight of the Registrant notwithstanding what is set out in the statement. The updating of the notes was a matter of grave concern to the Committee. Certainly, these notes do not reflect well on the Registrant and in their execution, demonstrate a lack of insight.

6. The Committee carefully considered the Transcripts of the hearing as well as the advices given and the submissions made. As advised, the Committee commenced its consideration of sanction with the least permitted sanction under the Act, that is, admonishment or censure. In view of the findings made the Committee is of the view that, even having taken all mitigating factors into account, neither of these sanctions in and of themselves are adequate to address the seriousness of the underlying conduct nor would it uphold the reputation of the profession or act as a deterrent to other

Physiotherapists. Such a sanction in and of itself would not uphold public confidence in the profession or adequately protect the public.

7. The Committee then turned to the next permitted sanction, namely, the attachment of conditions to the Registrant's registration including restrictions on the practice of the designated profession by the Registrant. While noting the remediation undertaken already by the Registrant, the Committee was concerned to note that the Registrant has not worked as a Physiotherapist for the last 2 plus years aside from a single day's work as outlined in her statement. The Committee accepts that conditions should be capable of being complied with, should be clear, appropriate, time defined and measurable and not prohibit the Registrant from practicing. While the Committee noted the remediation undertaken by the Registrant, the Committee also noted that the CPD carried out by the Registrant did not involve any clinical practice and further, that the courses attended did not seem to encompass any clinical exercises or supervision. In essence, as far as the Committee can see, the remediation has been entirely paper based without any practice/practical elements save for the one day on 4th February, 2025. As the Committee is acutely aware, these unfortunate events arose in the context of clinical practice and therefore the protection of the public requires that the regulatory authority should be satisfied that the Registrant can put into practice and demonstrate putting into practice the learnings she has taken from the courses attended and the CPDs undertaken.

8. The Committee accepts that insight has been demonstrated on paper and in evidence the Registrant told the Committee of the learning she had taken from these events. However, apart from one day in a physiotherapy practice where four patients were reviewed, the Registrant has not been in a position to implement and/or deal with diagnoses on an ongoing basis and this needs to be addressed, in the interest of public safety and upholding the reputation of the profession. It is for the foregoing reasons therefore that the Committee recommend the attachment of the above conditions to the registration of the Registrant's registration. The Committee wishes to point out that it is for a very limited period. The Committee would urge upon the Registrant to approach this period of supervision as an opportunity to put into clinical practice the learning she has taken from the paper exercises she has undertaken.

9. The Committee are conscious that there are important elements in the public interest which are engaged in a regulatory hearing including pointing out to the profession the gravity and seriousness of conduct such as this, the upholding of professional standards and the integrity of the fitness to practice regime and maintaining trust in the profession by reassuring the public as to the standards to be upheld by Practitioners. Whilst the Committee accepts, as has been advised, that insight is the best protection against a repetition of the conduct in issue, the Committee must also have regard to the foregoing factors and the extent of the insight demonstrated. At the core of this case was the failure by the Registrant to recognise and act upon a deteriorating presentation coupled with a failure by her to review her diagnosis in the light of the escalating presentations. Further, the Committee have concerns about the manner of the updating of the "*updated records"* and the evidence of the Registrant where she tried to minimise or qualify her own original notes. This greatly concerned the Committee. The Committee are therefore of the view that the Registrant's notetaking and clinical decision making and review needs to be supervised in a practice setting so that CORU can be satisfied that the Registrant, in terms of her practice can implement the learning she has obtained on a theoretical basis.

In the opinion of the Committee, the sanction of censure coupled with a period of supervision for a 2 month period as outlined above prior to a return to practice would ensure the protection of the public, the upholding of public standards and benefit the Registrant in the remediation of the

deficiencies identified in this case. The Committee considers that the Sanction would be appropriate and proportionate in all of the circumstances.

Signed: Geraldine Feeney

Chairperson

Date: 20.11.2025