Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday, 1 February 2024

Virtual Meeting

Name of Registrant:	Janet Elaine Fryer
NMC PIN	81C3030E
Part(s) of the register:	RN1: Adult Nurse, Level 1 (May 1984)
Relevant Location:	North Yorkshire
Type of case:	Misconduct
Panel members:	Patricia Richardson (Chair, lay member) Hannah Harvey (Registrant member) Pam Campbell (Registrant member)
Legal Assessor:	John Moir
Hearings Coordinator:	Daisy Sims
Consensual Panel Determination:	Accepted
Facts proved:	Charges 1-16, 18b - 26
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mrs Fryer's registered email address by secure email on 13 November 2023.

Further, the panel noted that the Notice of Meeting was also sent to Mrs Fryer's representative at the Royal College of Nursing (RCN) on 13 November 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

In the light of all the information available, the panel was satisfied that Mrs Fryer has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge (as amended)

That you, a registered nurse:

1. Between April 2018 and September 2018 failed to complete monthly care plans.
[ADMITTED]

2. Between June 2017 and September 2018 failed to complete necessary audits for; **[ADMITTED in entirety]**

a) kitchen;

b) pharmacy.

3. Over an unknown duration up to September 2018 failed to action necessary health and safety checks and actions as set out at Schedule 1.
[ADMITTED]

4. In or around February 2019, following Resident A having an

unwitnessed fall, failed to: **[ADMITTED in entirety]**

a) conduct a full body check immediately after the incident;

b) complete a serious injury form;

c) notify the family of the fall or the evident injuries;

d) notify the CQC;

e) record the details and update the care plan.

5. On 6 March 2019 and/or 7 March 2019 and/or 25 March 2019, when asked about Resident A, you stated that you had sent the serious incident report to the CQC by fax as the portal was down when this was not the case. **[ADMITTED]**

6. On 6 March 2019 you download a serious incident report from the CQC website. **[ADMITTED]**

7. On 6 March 2019 produced a completed serious injury form for Resident A and stated that it had been forwarded the CQC. **[ADMITTED]**

8. Your actions at charge 5 and/or 6 and/or 7 above were dishonest in that you were attempting to conceal the fact that you had not completed a serious incident form for Resident A. **[ADMITTED]**

9. Failed to safely administer medication to residents: **[ADMITTED in entirety]**

a) In or around March / April 2019 omitted to give Resident X her prescribed Co- beneldopa on one or more occasion.

b) At some time on October 2019 omitted to give Resident Y her prescribed Longtec medication having signed as given.

c) On 19 November 2019 omitted to give Resident Y her prescribed Longtec medication having signed as given.

d) On 21 April 2020 dispensed Parkinsons medication for Resident H but did not ensure that she had taken it.

e) On 20 July 2020 dispensed Parkinsons medication for Resident H but did not ensure that she had taken it.

f) On 7 September 2020 dispensed medication for Resident O but did not ensure that he had taken it.

g) On 7 September 2020 dispensed medication for Resident P but did not ensure that she had taken it.

h) Between 5- 8 October 2020 omitted to give Resident L a dose of Folic Acid.

10. On 26 September 2020 dispensed morning, lunchtime and teatime medications for Resident H and put them in the medication pod of Resident R. **[ADMITTED]**

11. On 26 September 2020 dispensed morning medications for Resident Q and put them in the medication pod of Resident R. **[ADMITTED]**

12. In or around July 2020 failed to create care plans for three residents within 72 hours of admission. **[ADMITTED]**

13. In or around September 2020 you failed to update care plans and risk assessments for residents in a timely manner.
[ADMITTED]

14. On 8 October failed to sign one or more MAR charts for residents set out in Schedule 2. **[ADMITTED]**

15. On 23 October failed to sign one or more MAR charts. **[ADMITTED]**

16. On 6 November 2020 placed dispensed medication for Resident L in Resident R's medication pod. **[ADMITTED]**

17. On 4 January 2021, disposed of medication intended for Resident B in the staff room waste bin. **NMC offer no evidence**

18. On dates between 30 November 2020 and 30 December 2020:

a) On 26 December 2020 did not give or did not sign as giving

Donepezil to Resident A; **NMC offer no evidence**

b) Omitted to give Resident D her Digoxin and Donepezil medication despite having signed as given; **[ADMITTED]**

c) On 30 December 2020 did not give or did not sign as giving Resident D her Apixaban and Donepezil medication and her Aymes shake; **[ADMITTED]**

d) On 6 December did not give or did not sign as giving Resident E his Donepezil medication; **[ADMITTED]**

e) Omitted to give Resident M her Mirtazipine medication having signed as given; **[ADMITTED]**

f) On 30 December 2020 did not give or did not sign as giving Resident F her inhaler. **[ADMITTED]**

19. On 26 December 2020 you recorded in the controlled drug book that you had dispensed a Butec patch for Resident N and signed the MAR chart to that effect when you had not done so. **[ADMITTED]**

20. On 3 January 2021 you did a weekly count of the controlled drugs for Resident N with Colleague A to correct the balance of the remaining Butec patches. **[ADMITTED]**

21. On 3 January 2021 you transferred the Butec patches from the original page and had the signing out witnessed by Colleague B. **[ADMITTED]**

22. You created a new page for the Butec patches and transferred them in with Colleague C. **[ADMITTED]**

23. Your actions in charges 21 and/or 22 and/or 23 above were dishonest in that you were attempting to conceal the fact that you had failed to administer the Butec patch on 26 December 2020 . **[ADMITTED]**

24. On 4 January 2021: **[ADMITTED in entirety]**

a) dispensed medication for Resident G;

b) discarded the medication in the staff room bin;

c) failed to record that Resident G had not had the medication.

25. Whilst employed at Beanlands (the "Home") as registered manager failed to conduct or delegate to be conducted staff supervision and appraisals. **[ADMITTED]**

26. Whilst employed at Beanlands (the "Home") as registered manager failed to notify the CQC of 23 deaths between the period July 2018 to March 2019. **[ADMITTED]**

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

Schedule 1

i. Maintenance checks in July and/or September 2018;

ii. That the Company vehicle was taxed;

iii. Wheelchair checks in July and/or September 2018;

iv. Check of the mobile hoist;

v. Window checks in July and/or September 2018;

vi. Fire tests were conducted on a weekly basis;

vii. Checks of the fire blankets and/or emergency lights.

Schedule 2

i. Resident S

ii. Resident G

iii. Resident T

iv. Resident U

v. Resident O

vi. Resident V

vii. Resident W

Consensual Panel Determination

At the outset of this meeting, the panel was made aware that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the Nursing and Midwifery Council (NMC) and Mrs Fryer.

The agreement, which was put before the panel, sets out Mrs Fryer's full admissions to the facts alleged in the charges, that her actions amounted to misconduct, and that her fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a striking-off order.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

'The Nursing & Midwifery Council ("the NMC") and Mrs Janet Elaine Fryer ('Mrs Fryer'), PIN 81C3030E ('the Parties') agree as follows:

2. *Mrs Fryer is aware of the CPD Meeting. Mrs Fryer is content for her case to be dealt with by way of a CPD meeting. Mrs Fryer understands that if the panel determines that substantial amendments are needed to the agreement, the panel will adjourn the matter for this provisional agreement to be considered at a CPD hearing.*

The charges

3. *Mrs Fryer faces following charges:*

That you, a registered nurse:

1. Between April 2018 and October 2018 failed to complete monthly care plans.

2. Between June 2017 and October 2018 failed to complete necessary audits for;

a) kitchen;

b) pharmacy.

3. Over an unknown duration up to September 2018 failed to action necessary health and safety checks and actions as set out at Schedule 1.

4. In or around February 2019, following Resident A having an unwitnessed fall, failed to:

a) conduct a full body check immediately after the incident;

b) complete a serious injury form;

c) notify the family of the fall or the evident injuries;

d) notify the CQC;

e) record the details and update the care plan.

5. On 6 March 2020 and/or 25 March 2020, when asked about Resident A, you stated that you had been unable to send the serious incident report to the CQC because the portal was down.

6. On 6 March 2019 you download a serious incident report from the CQC website.

7. On 6 March 2019 produced a completed serious injury form for Resident A and stated that it had been forwarded the CQC.

8. Your actions at charge 5 and/or 6 and/or 7 above were dishonest in that you were attempting to conceal the fact that you had not completed a serious incident form for Resident A.

9. Failed to safely administer medication to residents:

a) In or around March / April 2019 omitted to give Resident X her prescribed Co-beneldopa on one or more occasion.

b) At some time on October 2019 omitted to give Resident Y her prescribed

Longtec medication having signed as given.

c) On 19 November 2019 omitted to give Resident Y her prescribed Longtec medication having signed as given.

d) On 21 April 2020 dispensed Parkinsons medication for Resident H but did not ensure that she had taken it.

e) On 20 July 2020 dispensed Parkinsons medication for Resident H but did not ensure that she had taken it.

f) On 7 September 2020 dispensed medication for Resident O but did not ensure that he had taken it.

g) On 7 September 2020 dispensed medication for Resident P but did not ensure that she had taken it.

h) Between 5- 8 October 2020 omitted to give Resident L a dose of Folic Acid.

10. On 26 September 2020 dispensed morning, lunchtime and teatime medications for Resident H and put them in the medication pod of Resident R.

11. On 26 September 2020 dispensed morning medications for Resident Q and put them in the medication pod of Resident R.

12. In or around July 2020 failed to create care plans for three residents within 72 hours of admission.

13. In or around September 2020 you failed to update care plans and risk assessments for residents in a timely manner.

14. On 8 October failed to sign one or more MAR charts for residents set out in Schedule 2.

15. On 23 October failed to sign one or more MAR charts.

16. On 6 November 2020 placed dispensed medication for Resident L in Resident R's medication pod.

17. On 4 January 2021, disposed of medication intended for Resident B in the staff room waste bin.

18. On dates between 30 November 2020 and 30 December 2020:

a) On 26 December 2020 did not give or did not sign as giving Donepezil to Resident A;

b) Omitted to give Resident C her Digoxin and Donepezil medication despite having signed as given;

c) On 30 December 2020 did not give or did not sign as giving Resident C her Apixaban and Donepezil medication and her Aymes shake;

d) On 6 December did not give or did not sign as giving Resident D his Donepezil medication;

e) Omitted to give Resident E her Mirtazipine medication having signed as given;

f) On 30 December 2020 did not give or did not sign as giving Resident F her inhaler.

19. On 26 December 2020 you recorded in the controlled drug book that you had dispensed a Butec patch for Resident E and signed the MAR chart to that effect when you had not done so.

20. On 3 January 2021 you did a weekly count of the controlled drugs for Resident E with Colleague A to correct the balance of the remaining Butec patches.

21. On 3 January 2021 you transferred the Butec patches from the original page and had the signing out witnessed by Colleague B.

22. You created a new page for the Butec patches and transferred them in with Colleague C.

23. Your actions in charges 21 and/or 22 and/or 23 above were dishonest in that you were attempting to conceal the fact that you had failed to administer the Butec patch on 26 December 2020.

24. On 4 January 2021

a) dispensed medication for Resident G;

b) discarded the medication in the staff room bin;

c) failed to record that Resident G had not had the medication.

25. Whilst employed at Beanlands (the "Home") as registered manager failed to conduct or delegate to be conducted staff supervision and appraisals.

26. Whilst employed at Beanlands (the "Home") as registered manager failed to notify the CQC of 23 deaths between the period June 2018 to March 2019.

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

Schedule 1

i. *Maintenance checks in July and/or September 2018;*
ii. *That the Company vehicle was taxed;*
iii. *Wheelchair checks in July and/or September 2018;*
iv. *Check of the mobile hoist;*
v. *Window checks in July and/or September 2018;*
vi. *Fire tests were conducted on a weekly basis;*
vii. *Checks of the fire blankets and/or emergency lights.*

Schedule 2

i. *Resident S*
ii. *Resident G*
iii. *Resident T*
iv. *Resident U*
v. *Resident O*
vi. *Resident V*
vii. *Resident W*

Preliminary matters

Application to amend the charges

3. *The Parties apply to amend the current charges in line with rule 28 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004. This rule confirms that at any stage before a finding is made a panel may make amendments to the charges, or the facts set out within the charges, unless the Panel consider, having regard to the merits of the case and the fairness of the proceedings, the required amendments cannot be made without injustice. This NMC's guidance on finalising charges[1] further sets out that, when considering whether to amend charges, a panel should consider fairness and the NMC's overarching objective to protect the public.*

4. *The Parties agree that:*

4.1. The changes proposed do not materially affect the substance or seriousness of the charges;

4.2. The changes proposed are to correct minor drafting errors; and

4.3. The changes proposed better reflect the available evidence, and are accepted on behalf of Mrs Fryer.

5. *On the basis of the factors set out above, the Parties agree that it would be fair to amend the charges as set out below, and that this would not interfere with the NMC's overarching objective.*

Charges 1-2

6. *The parties apply to amend charges 1-2 to correct an error in the dates outlined.*

7. Charges 1 and 2 currently read as follows:

a. Between April 2018 and October 2018 failed to complete monthly care plans.

b. Between June 2017 and October 2018 failed to complete necessary audits for;

i. kitchen;
ii. pharmacy.

8. As outlined in further detail below at paragraph 53, the audit which showed a failure to complete the monthly care plans and a failure to complete the necessary audits for the kitchen and pharmacy was completed in September 2018 and, not October 2018.

9. The parties therefore ask for charges 1-2 to be amended to read:

a. Between April 2018 and September 2018 failed to complete monthly care plans.

b. Between June 2017 and September 2018 failed to complete necessary audits for;

i. kitchen;
ii. pharmacy.

<u>Charge 5</u>

10. The parties apply to amend charge 5 to correct errors in the dates outlined, and in the facts alleged.

11. Charge 5 currently reads as follows:

5. On 6 March 2020 and/or 25 March 2020, when asked about Resident A, you stated that you had been unable to send the serious incident report to the CQC because the portal was down.

12. *As outlined in further detail below at paragraphs 57, at meetings on 6, 7 and 25 March 2019, and not meetings on 6 and 25 March 2020, Mrs Fryer had outlined she had been unable to upload the serious incident report for Resident A to the Care Quality Commission ('CQC') portal, as the online portal had been down, so she had faxed it to the CQC.*

13. *The parties therefore ask for charge 5 to be amended to read:*

5. On 6 March 2019 and/or 7 March 2019 and/or 25 March 2019, when asked about Resident A, you stated that you had sent the serious incident report to the CQC by fax as the portal was down when this was not the case.

<u>Charges 18b-e</u>

14. *The parties apply to amend charges 18b-e to correct errors in the residents listed.*

<u>Charge 18b</u>

15. *Charge 18b currently reads as follows:*

b) Omitted to give Resident C her Digoxin and Donepezil medication despite having signed as given;

16. *As outlined in further detail below at sub-paragraphs 90.2 and 90.3, it was found that on 13 December 2020 Mrs Fryer did not administer Digoxin to Resident D, and on 19 December 2020 did not administer Donepezil to Resident D, despite having recorded that she had done this.*

17. *The parties therefore ask for charge 18b to be amended to read:*

    b) Omitted to give Resident D her Digoxin and Donepezil medication despite having signed as given;

    <u>Charge 18c</u>

18. *Charge 18c currently reads as follows:*

    c) On 30 December 2020 did not give or did not sign as giving Resident C her Apixaban and Donepezil medication and her Aymes shake;

19. *As outlined in further detail below at sub-paragraph 90.5, it was found that on 30 December 2020 Mrs Fryer did not sign Resident D's MAR chart to confirm she had administered Apixaban and Donepezil medication and her Aymes shake as required.*

20. *The parties therefore ask for charge 18c to be amended to read:*

    c) On 30 December 2020 did not give or did not sign as giving Resident D her Apixaban and Donepezil medication and her Aymes shake;

    <u>Charge 18d</u>

21. *Charge 18d currently reads as follows:*

    d) On 6 December did not give or did not sign as giving Resident D his Donepezil medication;

22. *As outlined in further detail below at sub-paragraph 90.1, it was found that on 6 December 2020 Mrs Fryer did not sign Resident E's MAR chart to confirm she had administered his Donepezil.*

23. The parties therefore ask for charge 18d to be amended to read:

d) On 6 December did not give or did not sign as giving Resident E his Donepezil medication;

<u>Charge 18e</u>

24. Charge 18e currently reads as follows:

e) Omitted to give Resident E her Mirtazipine medication having signed as given;

25. As outlined in further detail below at sub-paragraph 90.4, it was found that on 26 December Mrs Fryer did not administer Mirtazipine to Resident M, despite having recorded that she had done this.

26. The parties therefore ask for charge 18e to be amended to read:

e) Omitted to give Resident M her Mirtazipine medication having signed as given;

<u>Charges 19-20</u>

27. The parties apply to amend charges 19 to correct errors an error in the resident listed.

28. Charges 19-20 currently reads as follows:

19. On 26 December 2020 you recorded in the controlled drug book that you had dispensed a Butec patch for Resident E and signed the MAR chart to that effect when you had not done so.

20. On 3 January 2021 you did a weekly count of the controlled drugs for Resident E with Colleague A to correct the balance of the remaining Butec patches.

29. *As outlined in further detail below at paragraph 91, it was found that on 26 December 2020 Mrs Fryer failed to administer a Butec Patch to Resident N, not Resident E, despite having recorded that she had done this.*

30. *The parties therefore ask for charges 19-20 to be amended to read:*

19. On 26 December 2020 you recorded in the controlled drug book that you had dispensed a Butec patch for Resident N and signed the MAR chart to that effect when you had not done so.

20. On 3 January 2021 you did a weekly count of the controlled drugs for Resident N with Colleague A to correct the balance of the remaining Butec patches.

<u>Charge 26</u>

31. *The parties apply to amend charge 26 to correct a material error in the dates outlined.*

32. *Charge 26 currently reads as follows:*

26. Whilst employed at Beanlands (the "Home") as registered manager failed to notify the CQC of 23 deaths between the period June 2018 to March 2019.

33. *As outlined in further detail below at paragraphs 60-61, Mrs Fryer failed to notify the CQC of patient deaths occurring between July 2018 and March 2019, rather than between June 2018 and March 2019.*

34. *The parties therefore ask for charges 26 to be amended to read:*

26. Whilst employed at Beanlands (the "Home") as registered manager failed to notify the CQC of 23 deaths between the period July 2018 to March 2019.

Proposed charges as amended

35. *The proposed charges as amended are as follows:*

That you, a registered nurse:

1. *Between April 2018 and September 2018 failed to complete monthly care plans.*

2. *Between June 2017 and September 2018 failed to complete necessary audits for;*

    a. *kitchen;*
    b. *pharmacy.*

3. *Over an unknown duration up to September 2018 failed to action necessary health and safety checks and actions as set out at Schedule 1.*

4. *In or around February 2019, following Resident A having an unwitnessed fall, failed to:*

    a. *conduct a full body check immediately after the incident;*
    b. *complete a serious injury form;*
    c. *notify the family of the fall or the evident injuries;*
    d. *notify the CQC;*
    e. *record the details and update the care plan.*

5. *On 6 March 2019 and/or 7 March 2019 and/or 25 March 2019, when asked about Resident A, you stated that you had sent the serious incident report to the CQC by fax as the portal was down when this was not the case.*

6. *On 6 March 2019 you download a serious incident report from the CQC website.*

7. *On 6 March 2019 produced a completed serious injury form for Resident A and stated that it had been forwarded the CQC.*

8. *Your actions at charge 5 and/or 6 and/or 7 above were dishonest in that you were attempting to conceal the fact that you had not completed a serious incident form for Resident A.*

9. *Failed to safely administer medication to residents:*

    a. *In or around March / April 2019 omitted to give Resident X her prescribed Co- beneldopa on one or more occasion.*
    b. *At some time on October 2019 omitted to give Resident Y her prescribed Longtec medication having signed as given.*
    c. *On 19 November 2019 omitted to give Resident Y her prescribed Longtec medication having signed as given.*
    d. *On 21 April 2020 dispensed Parkinsons medication for Resident H but did not ensure that she had taken it.*
    e. *On 20 July 2020 dispensed Parkinsons medication for Resident H but did not ensure that she had taken it.*
    f. *On 7 September 2020 dispensed medication for Resident O but did not ensure that he had taken it.*
    g. *On 7 September 2020 dispensed medication for Resident P but did not ensure that she had taken it.*
    h. *Between 5- 8 October 2020 omitted to give Resident L a dose of Folic Acid.*

10. *On 26 September 2020 dispensed morning, lunchtime and teatime medications for Resident H and put them in the medication pod of Resident R.*

11. *On 26 September 2020 dispensed morning medications for Resident Q and put them in the medication pod of Resident R.*

12. *In or around July 2020 failed to create care plans for three residents within 72 hours of admission.*

13. *In or around September 2020 you failed to update care plans and risk assessments for residents in a timely manner.*

14. *On 8 October failed to sign one or more MAR charts for residents set out in Schedule 2.*

15. *On 23 October failed to sign one or more MAR charts.*

16. *On 6 November 2020 placed dispensed medication for Resident L in Resident R's medication pod.*

17. *On 4 January 2021, disposed of medication intended for Resident B in the staff room waste bin.*

18. *On dates between 30 November 2020 and 30 December 2020:*

    a. *On 26 December 2020 did not give or did not sign as giving Donepezil to Resident A;*
    b. *Omitted to give Resident D her Digoxin and Donepezil medication despite having signed as given;*
    c. *On 30 December 2020 did not give or did not sign as giving Resident D her Apixaban and Donepezil medication and her Aymes shake;*
    d. *On 6 December did not give or did not sign as giving Resident E his Donepezil medication;*
    e. *Omitted to give Resident M her Mirtazipine medication having signed as given;*
    f. *On 30 December 2020 did not give or did not sign as giving Resident F her inhaler.*

19. *On 26 December 2020 you recorded in the controlled drug book that you had dispensed a Butec patch for Resident N and signed the MAR chart to that effect when you had not done so.*

20. *On 3 January 2021 you did a weekly count of the controlled drugs for Resident N with Colleague A to correct the balance of the remaining Butec patches.*

21. *On 3 January 2021 you transferred the Butec patches from the original page and had the signing out witnessed by Colleague B.*

22. *You created a new page for the Butec patches and transferred them in with Colleague C.*

23. *Your actions in charges 21 and/or 22 and/or 23 above were dishonest in that you were attempting to conceal the fact that you had failed to administer the Butec patch on 26 December 2020.*

24. *On 4 January 2021*

    a. *dispensed medication for Resident G;*
    b. *discarded the medication in the staff room bin;*
    c. *failed to record that Resident G had not had the medication.*

25. *Whilst employed at Beanlands (the "Home") as registered manager failed to conduct or delegate to be conducted staff supervision and appraisals.*

26. *Whilst employed at Beanlands (the "Home") as registered manager failed to notify the CQC of 23 deaths between the period July 2018 to March 2019*

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

Schedule 1

viii. Maintenance checks in July and/or September 2018;

ix. That the Company vehicle was taxed;

x. Wheelchair checks in July and/or September 2018;

xi. Check of the mobile hoist;

xii. Window checks in July and/or September 2018;

xiii. Fire tests were conducted on a weekly basis;

xiv. Checks of the fire blankets and/or emergency lights.

Schedule 2

viii. Resident S

ix. Resident G

x. Resident T

xi. Resident U

xii. Resident O

xiii. Resident V

xiv. Resident W

Offering no evidence

36. The NMC offers no evidence in respect of charges 17 and 18a.

37. As set out in the case of PSA v NMC & X [2018] EWHC 70 (Admin) by Laing J at paragraph 55, "even though this is not expressly provided for in the Rules[2], it must be open to the NMC, in an appropriate case, to offer no evidence."

38. The guidance published by the NMC in relation to offering no evidence[3] states:

“We will only offer no evidence in a particular case if it fits with our overarching objective.

We’ll only apply to offer no evidence against a nurse, midwife or nursing associate in the following circumstances:

- *When a particular part of the charge adds nothing to the overall seriousness of the case.*
- *When there is no longer a realistic prospect of some or all of the factual allegations being proved.*
- *When there is no longer a realistic prospect of a panel finding that the nurse, midwife or nursing associate's fitness to practise is currently impaired."*

39. *The Parties agree that it would be unfair to proceed with charges 17 and 18a as these charges stem from a misunderstanding of the evidence, and the factual allegations are not capable of being proved.*

Charge 17

40. *Charge 17 reads as follows:*

17. On 4 January 2021, disposed of medication intended for Resident B in the staff room waste bin.

41. *As set out in paragraph 94 below, and as reflected in charges 24a and 24b, on 4 January 2021 Mrs Fryer was found to have disposed of Resident G's medication in the staff room waste bin, and not Resident B. This is reflected in statements obtained from Ms 1, Regional Manager for Sutton Hall at the relevant time, and Ms 2, an agency nurse who discovered the medication in the bin.*

42. *There is no evidence to suggest Mrs Fryer disposed of medication intended for Resident B in the staff room waste bin. This charge was drafted in error and the Parties agree the factual allegation is not capable of being proved.*

Charge 18a

43. *Charge 18a reads as follows:*

a) On 26 December 2020 did not give or did not sign as giving Donepezil to Resident A;

44. *As set out in paragraph 90 below, the sub particulars of charge 18 are evidenced by an internal investigation, undertaken by Ms 1, into medications not being given as prescribed. The findings of this investigation are reflected in charges 18b-f as amended, and are supported by the statement of Ms 1. There is no evidence to suggest that on 26 December 2020 Mrs Fryer did not give, or did not sign as giving, Donepezil to Resident A. This charge was drafted in error and the Parties agree the factual allegation is not capable of being proved.*

Admissions

45. *Mrs Fryer admits to charges 1-16, and 18b-26 as amended.*

The facts

46. *Mrs Fryer appears on the register of nurses, midwives and nursing associates maintained by the NMC as a nurse specialising in adult care. Mrs Fryer has been on the NMC register since 1999.*

47. *Concerns have been raised in respect of Mrs Fryer's conduct while in employment at two nursing homes:*

    a. *Beanlands Nursing Home ('Beanlands')*

    b. *Sutton Hall and Lodge Care Home ('Sutton Hall')*

48. *On 5 February 2021, the NMC received a referral from Sutton Hall setting out numerous concerns in respect of Mrs Fryer's employment with them from 30 April 2019 until her resignation effective 24 February 2021. In the course of the NMC's*

investigation, information was also obtained relating to concerns with Mrs Fryer's employment at Beanlands between April 2018 and April 2019.

Beanlands

49. *Beanlands is a nursing home for residents of 65 years of age and above. Beanlands has a maximum capacity of 45 residents.*

50. *Mrs Fryer began work at Beanlands in 1983. Beanlands became part of the Czajka Care Group ('Czajka') in 2003. Mrs Fryer become the Registered Manager for Beanlands in or around 2014/2015. Mrs Fryer resigned from Beanlands effective 30 April 2019*

51. *Mrs Fryer's role, as the Registered Manager for Beanlands, was to oversee all aspects of Beanlands. This included:*

    51.1. Ensuring monthly care plans were completed for patients;

    51.2. Ensuring appropriate safety checks, actions, and audits were carried out within the home;

    51.3. Arranging for staff supervision/appraisal meetings to be conducted for each member of staff four times per year;

    51.4. Ensuring serious incident reports were completed and sent to the CQC; and

    51.5. Ensuring the CQC were notified when a resident died.

52. *The issues relating to Mrs Fryer's conduct while at Beanlands are set out in chronological order, and the charges covered by the period in question are outlined by the sub-headings.*

<u>Charges 1-3 and 25</u>

53. *In September 2018, Ms 9, the Senior Manager of Czajka, carried out a routine audit for Beanlands. As part of this audit it was discovered that:*

53.1. *Ten percent of resident care plans had not been completed since April 2018;*

53.2. *Kitchen and pharmacy audits had not been completed since June 2017.*

53.3. *There was no evidence of maintenance checks in July and September 2018;*

53.4. *The company vehicle was not taxed;*

53.5. *There was no evidence of a wheelchair checks in July and September 2018;*

53.6. *There was no evidence of window checks in July and September 2018;*

53.7. *There was no evidence of fire tests being conducted on a weekly basis;*

53.8. *There was no evidence that fire blankets or emergency lights had been checked over the course of the last year; and*

53.9. *Staff supervisions and appraisals at the home were out of date.*

Charges 4-8 and 26

54. *On or around January 2019, one of the female residents of Beanlands ('Resident A') fell suffering a fractured neck of femur.*

55. *In February 2019, a complaint was made to Beanlands by the daughter of Resident A stating that:*

55.1. *A full body check had not been conducted on Resident A after she had fallen;*

55.2. *Resident A's family had not been contacted about the swelling on Resident A's ankle;*

55.3. *Resident A's family had not been contacted about the bruise on Resident*

A's finger; aFnd

55.4. Resident A's family had not been contacted or consulted about their mother's care or care plans for the past 5 years.

56. On an unknown date prior to 6 March 2019, Ms Butler went into Beanlands while Mrs Fryer was on leave, but was unable to find any documentation relating to Resident A's fall.

57. On 6 and 7 March 2019 meetings were held with Mrs Fryer to discuss the concerns raised about Resident A. Mrs Fryer was asked whether she had completed a serious incident report form relating to the Resident A's fall and sent it to the CQC. When asked about Resident A's fall, Mrs Fryer presented a print out of a serious incident form and outlined that she had faxed this over to the CQC at the time as their online portal was down. Mrs Fryer reiterated this explanation at a later meeting on 25 March 2019.

58. Evidence was subsequently obtained from Mrs Fryer's computer which demonstrated that she had not completed and the serious incident form at the time of Resident A's fall, and had in fact downloaded and completed the form on 6 March 2020.

59. On 8 March 2019, the Human Resources Manager for Czajka, Mr 3, contacted the CQC by telephone. The CQC confirmed over the phone they had never received a serious incident form regarding Resident A's fall.

60. On 12 March 2019, Mr 3 emailed the CQC to query if and when their portal had been down. The CQC confirmed the portal was fine at the relevant time. The CQC also outlined that they had not received any notifications at all from Beanlands since July 2018. When further clarification was sought by Mr 3, it was confirmed by the CQC that they had not received any notification from Beanlands including patient deaths since July 2018.

61. Following the above correspondence with the CQC, a review was conducted of patient deaths at Beanlands. It was confirmed that 23 patients died between 4 July 2018 and 6 March 2019 at Beanlands, and none of these deaths were reported to the CQC.

Sutton Hall

62. Sutton hall is a nursing home for residents who require nursing and residential care.

Sutton Hall also cares for residents with dementia. Sutton Hall has a maximum capacity of 60 residents. At the time Mrs Fryer was working as the Clinical Lead Nurse there were approximately 45 residents staying in Sutton Hall.

63. *Mrs Fryer was employed as a Clinical Lead Nurse at Sutton Hall through Burlington Care Limited ('Burlington') from 30 April 2019 until her resignation effective 24 February 2021. Mrs Fryer was responsible for approximately 20-22 residents at any one time. Mrs Fryer's duties included creating and updating care plans, as well as dispensing and administering medication.*

64. *On 30 December 2020 Sutton Hall received details of an anonymous complaint made to the CQC in respect of Mrs Fryer. Mrs Fryer was suspended whilst the allegations were investigated by the Home in January 2021.*

65. *The issues relating to Mrs Fryer's conduct while at Sutton Hall are set out in chronological order, and the charges covered by the period in question are outlined by the sub-hearings.*

<u>Charge 9a</u>

66. *During a nightshift on an unknown date in or around March/April 2019, Ms 4, another Clinical Lead Nurse working at Sutton Hall, administered Resident X Co-beneldopa for her Parkinson's disease. When Ms 4 had finished administering the prescribed medication, she counted the remaining tablets in the bottle in line with the Home's medication administration procedure. Ms 4 discovered that there were 3 extra tablets left in the Co-beneldopa bottle. This was confirmed by another carer on shift when they also counted the remaining tablets in the bottle in comparison to the tally on the medication chart. As Mrs Fryer had signed off as administering the medication to Resident X the previous shift, the extra tablets indicated that Mrs Fryer had not administered Resident X's Co-beneldopa.*

67. *Ms 4 then informed the home manager about the incident and completed an incident report form.*

<u>Charges 9b-c</u>

68. *At some time in October 2019, after she had completed a drug round, Ms 4 noticed when counting Resident Y's Longtec tablets and comparing them to the controlled drug book and MAR chart that there was one additional Longtec tablet. Mrs Fryer had signed the controlled drug book and MAR chart to say that she had administered Resident Y's Longtec tablet that morning. As Mrs Fryer had signed off as administering the medication to Resident Y the previous shift, the extra tablet indicated that Mrs Fryer had failed to properly administer Resident Y's Longtec tablet.*

69. *On 19 November 2019, Ms 4 noticed again that there was an additional Longtec tablet not accounted for in the controlled drug book or MAR chart, which should have been administered to Resident Y by Mrs Fryer.*

70. *Ms 4 filed incident reports after both these occasions.*

<u>Charges 9d-e</u>

71. *On 21 April 2020, Mrs Fryer, as the only nurse on duty at the time, was responsible for dispensing and administering Resident H's Parkinsons medication tablet. It is standard practise for a nurse to stay with any resident once medication has been dispensed to ensure they take it. Resident H was required to take two Parkinsons tablets at approximately 8am and 2pm.*

72. *At approximately 9.15am on 21 April 2020, Sutton Hall's Activities Coordinator, Ms 5, attended to Resident H to see if she needed any help with her breakfast as she sometimes required assistance. Ms 5 noticed Resident H's Parkinsons tablet in a plastic medicine pot by the side of her television. Ms 5 returned to Resident H's bedroom at approximately 11.45am and found the medication was still there.*

73. *Ms 5 proceeded to take this medication to Mrs Fryer to raise her concerns, and made a note in her incident diary.*

74. *On the afternoon of 20 July 2020, Ms 5 was conducting an activity with Resident H and other residents of Sutton Hall. At approximately 1.45pm Ms Mrs Fryer came down and gave Resident H her Parkinsons tablet.*

75. *At around 2.45pm on 20 July 2020, as Ms 5 was clearing away after the activity, it was noted that Resident H was in fact still holding on to her Parkinsons tablet and had*

not taken this. Ms 5 took Resident H back to her bedroom, raised the incident with Mrs Fryer, and made a note in her incident diary.

Charge 12

76. *On 6 July 2020, the home manager for Sutton Hall at the time, Mr 6, noticed and raised with Mrs Fryer that she had failed to create care plans for three newly admitted residents within 72 hours as required. Mr 6 wrote to Mrs Fryer to raise his concerns about this.*

Charges 9f-g

77. *On the morning of 7 September 2020, Mrs Fryer dispensed medication for Residents O and P, a married couple.*

78. *At approximately 9.15am on 7 September 2020, Ms 5 was assisting with breakfast in the dining room and noticed that medication for Residents O and P was on the table next to them. At 12pm mid-day, Ms 5 was preparing for activities in the dining room when she noticed the medication for Residents O and P was still sitting on the dining table in pots.*

79. *Ms 5 raised concerns that she had now encountered several occasions where Mrs Fryer had dispensed medication for Residents but had failed to ensure they took their medication.*

Charge 13

80. *On 22 September 2020, Mr 6 noticed and raised with Mrs Fryer that three resident care plans and risk assessments had not been completed, and had been flagged by Sutton Hall's electronic care plan system as overdue by one month.*

Charges 10-11

81. *On 26 September 2020, Ms 7, a registered nurse at Sutton Hall, was working a day shift and preparing medication for the residents. Whilst preparing to give the medication to Resident R Ms 7 discovered 2 medicine pots of tablets where Resident R's medication is stored which were not for Resident R. One of the pots belonged to Resident H, and the other to Resident Q. Ms 7 was able to determine this as Resident H was prescribed a very distinctive big orange pill, Stalevo, and Resident Q was the only resident at the time taking 1g Metformin tablets. This medication would have been prepared by Mrs Fryer as she was the nurse on the day shift on 25 September 2020, and both pots contained medication to be administered to Residents H and Q in the day.*

82. *Ms 7 subsequently reported these matters and filled out an incident form.*

<u>Charge 9h</u>

83. *On 8 October 2020, Ms 7 was dispensing medication for residents including Resident L. Resident L takes a Folic Acid tablet 6 days per week. At the start of the week, 24 tablets were made available to administer to Resident L. Mrs Fryer had recorded administering one tablet on 5 October 2020, and one tablet on 7 October 2020. Despite Mrs Fryer having recorded that she had administered 2 Folic Acid tablets to Resident L that week, after Ms 7 dispensed Resident L's tablet for 8 October 2020, there were still 22 tablets remaining. If Mrs Fryer had correctly administered tablets to Resident L on 5 and 7 October, after the tablet was dispensed for 8 October 2020, there should have been 23 tablets. It was therefore clear Mrs Fryer had failed to dispense and administer one of Resident L's Folic acid tablets between 5 and 8 October as recorded.*

84. *Ms 7 subsequently reported these matters and filled out an incident form.*

<u>Charge 14</u>

85. *In the course of administering medication Ms 7 noticed on several occasions Mrs Fryer did not provide signatures on MAR charts to confirm medication had been administered in respect of residents. This presented a problem as this indicated*

residents may not have received their medication.

86. Ms 7 noticed that Mrs Fryer had failed to provide signatures for seven residents on 8 October 2020. These residents were:

86.1. Resident S;

86.2. Resident G;

86.3. Resident T;

86.4. Resident U;

86.5. Resident V; and

86.6. Resident W. *Charge 15*

87. On 29 October 2020, Ms 1, Regional Manager for Sutton Hall at the time, carried out a routine medication check. During this check Ms 1 discovered that on 23 October 2020, despite having purportedly administered medication to those residents who had needed it at lunch time, Mrs Fryer had failed to sign their MAR charts to reflect this.

Charge 16

88. On 7 November 2020, whilst preparing to give the medication to Resident R, Ms 7 noticed that the medication in Resident R's pot was not the correct medication. Ms 7 was able to discern from the type and amount of medication that this medication belonged to Resident L. This medication was due to be given to Resident L on 6 November 2020 by Mrs Fryer, and must have been placed in Resident R's pot by Mrs Fryer on 6 November 2020.

89. Ms 7 subsequently reported these matters and filled out an incident form.

Charges 18b-f

90. On 31 December 2020, following an anonymous concern raised through the CQC, Ms 1 commenced an internal investigation into medications not being given as prescribed.

As part of the investigation the following discoveries were made:

90.1. On 6 December 2020, Resident E should have been administered 10mg of Donepezil. However, the signature on the MAR Chart was missing to state that it had been administered. Mrs Fryer was the nurse on shift with responsibility for administering medication to Resident D.

90.2. On 13 December 2020, Mrs Fryer recorded that she had administered Digoxin to Resident D. When the medication stock was checked it was confirmed there was one additional tablet. It was therefore concluded that Mrs Fryer had failed to administer Digoxin to Resident C on 13 December 2020.

90.3. On 19 December 2020, Mrs Fryer recorded that she had administered Donepezil to Resident D. When the medication stock was checked it was confirmed there was one additional tablet. It was therefore concluded that Mrs Fryer had failed to administer Donepezil to Resident D on 19 December 2020.

90.4. On 26 December 2020, Mrs Fryer recorded that she had administered Mirtazapine to Resident M. When the medication stock was checked it was confirmed there was one additional tablet. It was therefore concluded that Mrs Fryer had failed to administer Mirtazapine to Resident M on 26 December 2020.

90.5. On 30 December 2020, Resident D should have been administered Apixaban Donepezil and her Amyes shake medication. However, the signature on the MAR Chart was missing to state that it had been administered. Mrs Fryer was the nurse on shift with responsibility for administering medication to Resident D.

90.6. On 30 December 2020, Resident F should have been given his inhaler. However, the signature on the MAR Chart was missing to state that it had been given. Mrs Fryer was the nurse on shift with responsibility for providing this inhaler to Resident F.

<u>Charges 19-23</u>

91. *On 2 January 2021 Ms 7 and a senior carer, Colleague A (referred to in the charges as 'Colleague A'), were preparing to apply a transdermal Butec patch to Resident N. Resident N was prescribed a weekly Butec patch for pain relief. After reviewing Resident N's MAR chart and the controlled drug book records, Ms 7 and Colleague A discovered that there were four patches left in the medication box when there should have been three. Ms 7 and Colleague A also checked the patch currently on Resident N's arm which was dated 19 December 2020, rather than 26 December 2020. Mrs Fryer had signed Resident N's MAR chart on 26 December 2020 to record she had administered Resident N's Butec. Based on the patches remaining it was concluded by Ms 7 and Colleague A that Mrs Fryer had failed to administer Resident N's Butec patch on 26 December 2020, and the patch from 19 December 2020 had been left on for two weeks.*

92. *On 3 January 2021, Colleague A spoke to Mrs Fryer about her concerns regarding the Butec patches. When confronted about this error Mrs Fryer denied her mistake and outlined she had administered Resident N's Butec patch as recorded. Mrs Fryer later was responsible for conducting a weekly count of controlled drugs for Resident N where she recorded that there were four patches, and had Colleague A countersign this.*

93. *At some point during her shift on 3 January 2021, Mrs Fryer transferred the record of Resident N's Butec patches to another page in the controlled drug book and clipped this to unused pages, striking through the old records. Mrs Fryer had Colleague B, referred to in the charges as Colleague B, sign off the striking through and transfer of the original records, and Colleague C, referred to in the charges as Colleague C, sign off the new page which the medication record was transferred onto. When reviewed in the context of information from Ms 7 and Colleague A, it was concluded that Mrs Fryer's actions on 3 January 2021 had been carried out in an attempt to hide her error in failing to administer a Butec patch to Resident N on 26 December 2020.*

<u>Charges 24a-c</u>

94. *On 4 January 2021, Ms 2, an agency nurse working at Sutton Hall, took her break in the staff break room. During Ms 2's break Mrs Fryer walked in and disposed of something in the waste bin. Ms 2 finished her break and went to dispose of a paper*

towel she used to wipe down the table she had used on her break. Ms 2 then discovered a squashed paper medicine pot Mrs Fryer had disposed of which contained several tablets and capsules. These tablets included yellow tablets

which were prescribed to Resident G which Ms 2 confirmed with the deputy nurse manager at Sutton Hall, Ms 8. Mrs Fryer had dispensed the medication for Resident G, but had failed to administer it. No record was made by Mrs Fryer of Resident G refusing medication.

95. *Ms 2 subsequently reported these matters.*

Misconduct

96. *Mrs Fryer admits that the conduct as particularised in charges 1-16, and 18b-26 as amended as amended amounts to misconduct.*

97. *Although not defined in statute, the comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 provide some assistance when seeking to define misconduct:*

"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [registered professional] in the particular circumstances".

98. *In addition the comments of Jackson J in Calhaem v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), are instructive namely:*

"[Misconduct] connotes a serious breach which indicates that the [registered professional's] fitness to practise is impaired."

And

“The adjective “serious” must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner.”

99. Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Code[4].

100. The Parties agree the following provisions of the Code, to which Mrs Fryer was subject to as a registered nurse at all relevant times, have been breached in this case:

*"**1 Treat people as individuals and uphold their dignity***

1.2 make sure you deliver the fundamentals of care effectively

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

8 Work co-operatively

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

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

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all time, treating people fairly and without discrimination, bullying or harassment

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

101. Mrs Fryer admits that she failed to deliver the fundamentals of care effectively and without undue delay to patients by:

101.1. Failing to complete care plans;

101.2. Failing to take appropriate actions after a resident had a serious fall; and

101.3. Failing to administer medication to residents as prescribed.

102. Mrs Fryer admits that she failed to work co-operatively with colleagues by:

102.1. Failing to maintain appropriate and accurate records for patients;

102.2. Failing to report incidents to senior colleagues as required; and

102.3. Overwriting patient records written by other colleagues to cover her own mistakes.

103. Mrs Fryer admits that she failed to keep clear and accurate records by:

103.1. Failing to complete monthly care plans;

103.2. Failing to complete audits as necessary;

103.3. Failing to complete a serious injury form when required;

103.4. Failing to record when medication had been administered to residents; and

103.5. Creating inaccurate/false records in an attempt to hide her mistakes.

104. Mrs Fryer admits that her actions as outlined above placed patients at unnecessary risk of harm.

105. Mrs Fryer admits that her actions as outlined above demonstrated a lack of honesty and integrity and failed to uphold the values set out in the code.

106. Mrs Fryer admits that her actions as outlined in charges 1-8, relating to her time as Registered Manager for Beanlands, failed to provide leadership which ensured staff were appropriately managed, and an appropriate level of service was provided to Residents.

107. It is acknowledged that not every breach of the Code will result in a finding of misconduct. However, Mrs Fryer accepts that the failings set out above represent a serious departure from the professional standards and behaviour expected of a registered nurse.

108. As outlined by Rodger LJ in the case of Patel v General Medical Council [2003] UKPC 16 "a finding of dishonesty lies at the top end in the spectrum of gravity of misconduct".

Impairment

109. The Parties agree that Mrs Fryer's fitness to practise is currently impaired by reason of her misconduct.

110. The NMC's guidance on impairment[5] explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. The guidance does however set out that a panel, when considering if a nurse is impaired, should start by considering "Can the nurse, midwife or nursing associate practise kindly, safely and professionally?". The guidance states that, if the answer to that question is yes, the individual's fitness to practise is not likely to be impaired. In this case the Parties agree that that Mrs Fryer cannot currently practise kindly, safely, and professionally. The guidance goes on to state that, before considering impairment, the Committee must decide on the facts proven, and whether those facts prove the

charges in the case. In this case Mrs Fryer has fully admitted to the facts and charges.

111. Although there is no statutory definition of impairment, the questions outlined by Dame Janet Smith in the 5th Shipman Report ('the Shipman report'), as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), provide further guidance on impairment. Those questions were:

111.1. "has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or

111.2. has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or

111.3. has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future; and/or

111.4. has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future."

112. The Parties agree that all four of the above questions can be answered in the affirmative when considering Mrs Fryer's actions in this case.

113. In respect of the first question, Mrs Fryer's actions in failing to keep resident care plans up to date, failing appropriate administer medication to residents, and failing to take appropriate actions after a patient fell, had the potential to place vulnerable residents within both Sutton Hall and Beanlands at risk of harm.

114. In respect of the second question, Mrs Fryer's actions in failing to appropriately

manage Beanlands, and failing to administer medication appropriately to patients then seeking to conceal her mistakes, are significantly liable to bring the profession into disrepute as they represent actions falling far below the standards expected of a registered professional.

115. In respect of the third question, acting with honesty and integrity, and providing medication to patients as prescribed, represent fundamental tenets of the nursing profession, and Mrs Fryer's actions clearly breached these tenets.

116. In respect of the fourth question, in admitting to charges 8 and 23, Mrs Fryer has admitted to acting dishonestly.

117. In addition to the guidance for impairment set out in the Shipman report, the Parties also refer to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin). At paragraph 74 of this case Cox J commented that:

"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."

118. The consideration of impairment as outlined in this case can be broadly split into two distinct questions:

118.1. Whether Mrs Fryer poses a current risk to the public through her practice; and

118.2. Whether a finding of impairment is needed to maintain public confidence in the profession and uphold professional standards.

Current risk

119. Impairment is a forward-thinking exercise that looks at the risk a registrant's practice poses in the future. The NMC's guidance on impairment[6] adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied, and whether it is highly unlikely to be repeated.

120. The NMC's guidance on serious concerns which are more difficult to put right[7] outlines that such concerns will include "breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of staff or patient who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care."

121. Mrs Fryer's actions in dishonestly concealing her errors at both Beanlands and Sutton Hall, represent deep-seated attitudinal issues that would be difficult to put right.

122. Although Mrs Fryer has engaged with the NMC and admits her misconduct, Mrs Fryer has failed to address and put right the issues raised.

123. The Parties agree that, given Mrs Fryer's repeated failures in administering and appropriately recording the administration of medication, and given her repeated dishonesty to cover her mistakes, there is a real risk of further misconduct being repeated in the future.

124. Taking the above factors into account, the Parties agree that Mrs Fryer's fitness to

practise is impaired on the basis of a current risk to the public.

Public interest

125. The Parties agree that Mrs Fryer's conduct is so serious that a finding of impairment is needed to uphold professional standards, and avoid undermining public confidence and trust in the regulatory process and the NMC as a regulator.

Sanction

126. Whilst sanction is a matter for the panel's independent professional judgement, the Parties agree that the appropriate sanction in this case is a striking-off order.

127. The aggravating features of this case are agreed by the parties to be that:

127.1. Mrs Fryer's conduct falls within the definition of serious conduct that would be difficult to put right;

127.2. Mrs Fryer's conduct represents a pattern of dishonesty over a significant period; and

127.3. Mrs Fryer's conduct placed residents at serious risk of harm.

128. The mitigating features of this case are agreed by the parties to be that:

128.1. Mrs Fryer has engaged with the NMC and admitted to her conduct

129. Considering the facts of this case in line with the available sanctions in ascending order of seriousness:

Taking no further action

130. The NMC's guidance on taking no further action[8] indicates that a panel has a discretion to take no further action after a finding of impairment, but will only use that discretion rarely. The Parties are agreed the nature of this case is not exceptional and that taking no action would not be sufficient to protect the public, maintain standards, or maintain confidence in the profession and the NMC as a regulator.

Caution Order

131. The NMC's guidance on caution orders[9] indicates that a caution order is only appropriate if there's no risk to the public or patients, and the case is at the lower end of the spectrum of impaired fitness to practise. As set out above, Mrs Fryer's conduct is particularly serious by reason of her dishonesty, and the fact that her actions placed residents at significant risk of harm. Furthermore, given that Mrs Fryer's conduct was repeated during her employment with both Beanlands and Sutton Hall over the course of more than three years, there is a clear risk of repetition and therefore a risk to the public.

Conditions of Practice Order

132. The NMC's guidance on conditions of practice orders[10] outlines that the key consideration when looking at whether conditions of practice may be appropriate is whether conditions can be put in place that would be sufficient to protect patients and address public confidence in the profession and the NMC.

133. Given the nature and seriousness of Mrs Fryer's conduct, the parties are agreed that there are no conditions that could be drafted which would fully address the matters in issue.

134. Conditions of practice would therefore be insufficient to protect the public and meet the wider public interest.

<u>Suspension Order</u>

135. The NMC's guidance on suspension orders[11] outlines that a suspension order may be appropriate in cases "where the misconduct isn't fundamentally incompatible with the nurse, midwife or nursing associate continuing to be a registered professional, and [the NMC's] overarching objective may be satisfied by a less severe outcome than permanent removal from the register."

136. The Parties are agreed that this is a case where Mrs Fryer's conduct represents serious conduct that would be difficult to put right, and would be incompatible with Mrs Fryer remaining a registered professional.

<u>Striking-off Order</u>

137. The NMC's guidance on striking-off orders[12] outlines that, before imposing a striking-off order, a Fitness to Practise Committee should consider among other matters:

137.1. Whether the regulatory concerns about the nurse raise fundamental questions about their professionalism;

137.2. Whether public confidence in the profession can be maintained if the nurse is not removed from the register; and

137.3. Whether striking-off is the only sanction that would be sufficient to protect patients, members of the public, or maintain professional standards.

138. As outlined in the case of Naheed v General Medical Council [2011] EWHC 702 (Admin) by Parker J at paragraph 22, "where dishonest conduct is combined with a lack of insight, is persistent or is covered up, nothing short of erasure is like to be appropriate." In this instance Mrs Fryer has admitted to dishonesty on multiple occasions, has shown a lack of insight, and has admitted to attempting to cover up her actions.

139. The Parties are agreed for the reasons stated above Mrs Fryer's conduct is so serious that it raises fundamental concerns about her professionalism; public confidence would be affected if Mrs Fryer were not removed from the register; and a striking-off order is the only appropriate and proportionate sanction in the circumstances.

Interim order

140. The Parties are agreed an interim order is required in this case. An interim order is necessary for the protection of the public and otherwise in the public interest for the reasons given above. The interim order should be for a period of 18 months in the event that the panel's decision is appealed. The interim order should take the form of an interim suspension order.

The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The Parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.'

Here ends the provisional CPD agreement between the NMC and Mrs Fryer. The provisional CPD agreement was signed by Mrs Fryer on 10 January 2024 and the NMC on 29 January 2024.

Decision and reasons on applications within CPD

The panel first considered the application to amend the charges. It accepted the advice from the legal assessor regarding its power to amend the charges in terms of Rule 28. It accepted the reasons jointly put forward by the NMC and Mrs Fryer as set out at paragraphs 3 to 34.

The panel considered that the proposed amendments would clarify the issues for it to determine and could be made without injustice.

The panel determined to allow the amendments as proposed.

The panel next considered the NMC's application to offer no evidence on charges 17 and 18a. It accepted the advice from the legal assessor and the NMC Guidance at DMA-3. It accepted the reasons set out by the NMC as set out at paragraphs 36 to 44.

The panel determined to allow the application as proposed.

Decision and reasons on the CPD

The panel decided to accept the CPD.

The panel was satisfied that despite the lack of a wet ink signature on the CPD by Mrs Fryer, it was satisfied as to her agreement of the document having seen evidence of an email between her and the RCN dated 29 January 2024 in which Mrs Fryer states that she is happy to proceed, the subject of the email being '*NMC-CPD'*.

The panel heard and accepted the legal assessor's advice. He referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. He reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Mrs Fryer. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that Mrs Fryer admitted the facts of the charges. Accordingly, the panel was satisfied that the charges are found proved by way of Mrs Fryer's admissions as set out in the signed provisional CPD agreement.

Decision and reasons on impairment

The panel then went on to consider whether Mrs Fryer's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Mrs Fryer, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct, the panel endorsed paragraphs 96 to 108 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether Mrs Fryer's fitness to practise is currently impaired by reason of misconduct. In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

The panel determined that Mrs Fryer's fitness to practise is currently impaired. In this respect the panel endorsed paragraphs 109 to 125 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Mrs Fryer'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:

- Mrs Fryer's conduct falls within the definition of serious conduct that would be difficult to put right;
- Mrs Fryer's conduct represents a pattern of dishonesty over a significant period; and
- Mrs Fryer's conduct placed residents at serious risk of harm.

The panel also took into account the following mitigating features:

- Mrs Fryer has engaged with the NMC and admitted to her conduct.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Fryer'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 Mrs Fryer'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 Mrs Fryer'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 nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mrs Fryer's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Fryer's actions is fundamentally incompatible with Mrs Fryer remaining on the register.

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?*

Mrs Fryer's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Fryer's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel agreed with the CPD that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the

effect of Mrs Fryer's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

Decision and reasons on interim order

The panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Fryer's own interest. The panel heard and 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 interests. 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 agreed with the CPD 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.

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

That concludes this determination.