

Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Meeting
11 – 12 July 2019

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant: Joanne Mary Phelan

NMC PIN: 94I1752E

Part(s) of the register: Registered Nurse (Sub Part 1)
Adult Nursing – September 1997
Nurse Independent / Supplementary Prescriber
– September 2016

Area of Registered Address: England

Type of Case: Misconduct / Caution

Panel Members: Emma Boothroyd (Chair, Lay member)
Kitty Lamb (Registrant member)
Eileen Skinner (Lay member)

Legal Assessor: Nigel Mitchell

Panel Secretary: Caroline Pringle

Facts proved: All **except** 1(k)(ii)

Facts not proved: 1(k)(ii)

Fitness to practise: Impaired

Sanction: Striking-off order

Interim Order: Interim suspension order (18 months)

Details of misconduct charge (as amended)

That you whilst employed as a Nurse Practitioner at Ponteland Road and Battle Hill walk-in centres between March and August 2017;

1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;

a) On 17 August 2017 prescribed Patient B;

i) Naproxen 500mg tablets

[Found proved]

b) On 19 August 2017 prescribed Patient C;

i) Doxycycline 8 - 100mg capsules

ii) Codeine ~~56 – 15mg tablets~~ [100 – 15mg tablets]

iii) Amitriptyline ~~8 – 100mg capsules~~ [56 – 10mg tablets]

[Found proved in its entirety]

c) On August 20 2017 prescribed Patient D;

i) Codeine 56 – 15mg tablets

[Found proved]

d) On 9 April 2017 prescribed Patient E;

i) Codeine 28 – 15mg tablets

ii) Diazepam 6 – 2mg tablets

iii) Naproxen 56 – 500mg tablets

[Found proved in its entirety]

e) On 22 April 2017 prescribed patient F;

i) Diazepam 14 – 2mg tablets

- ii) Gabapentin 100 – 100mg capsules
- iii) Naproxen 56 – 500mg tablets

[Found proved in its entirety]

f) On 22 May 2017 prescribed patient G;

- i) Amitriptyline 28 – 25mg tablets
- ii) Diazepam 9 – 2mg tablets

[Found proved in its entirety]

g) On 28 June 2017 prescribed and/or generated a prescription for patient H,
for;

- i) Diazepam 14 – 2mg tablets
- ii) 300ml bottle of 10mg/5m Morphine Sulphate

[Found proved in its entirety]

h) On 28 June 2017 prescribed a ~~300ml~~ [100ml] bottle of 10mg/5ml Morphine
Sulphate to Patient I;

[Found proved]

i) On 28 June 2017 prescribed Patient J;

- i) Diazepam 9 – 2mg tablets
- ii) Codeine 32 – 30mg tablets

[Found proved in its entirety]

j) On 4 July 2017 prescribed and/or generated a prescription for Patient K,
for;

- i) Codeine 56 – 15mg tablets
- ii) 500ml bottle of 10mg/5ml Morphine Sulphate

[Found proved in its entirety]

k) On 9 July 2017 prescribed for Patient L;

- i) Codeine 56 – 30mg tablets **[Found proved]**
 - ii) 500ml bottle of 10mg/5ml Morphine Sulphate **[Found NOT proved]**

- l) On 9 July 2017 prescribed Patient M, for;
 - i) Codeine 56 – 15mg tablets
 - ii) Diazepam 6 – 2mg tablets**[Found proved in its entirety]**

- m) On 14 July [August] 2017 prescribed Patient N;
 - i) Codeine 56 – 30mg tablets
 - ii) Diazepam 14 – 2mg tablets**[Found proved in its entirety]**

- n) On 14 August 2017 prescribed and/or generated a prescription for Patient O, for;
 - i) 500 ml bottle of 10mg/5ml Morphine Sulphate**[Found proved in its entirety]**

- 2) On 28 June 2017 inappropriately conducted a consultation with Patient J who had been involved in a road traffic accident. **[Found proved]**

- 3) On 9 July 2017 inappropriately conducted a consultation with Patient M who had been involved in a road traffic accident. **[Found proved]**

- 4) On 14 August 2017 inappropriately conducted a consultation with Patient N who was experiencing symptoms of a chronic and ongoing condition for which they were already receiving treatment. **[Found proved]**

- 5) On 14 August 2017 did not refer Patient N back to her GP or treating specialist. **[Found proved]**

- 6) On 14 August 2017 inappropriately conducted a consultation with Patient P who was exhibiting pregnancy related symptoms **[Found proved]**
- 7) On 14 August did not refer Patient P to a Gynaecology department. **[Found proved]**

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

Details of caution charge

That you a registered nurse,

1. On the 8th of September 2017 were cautioned by Northumbria Police as you “Between 1 August – 28 August 2017 obtained medical prescriptions during working duty committing fraud by false representation,” contrary to section 2 of the Fraud Act 2006. **[Found proved]**

And in light of the above your fitness to practise is impaired by reason of your caution

Decision on service of notice of meeting

The panel considered whether notice of this meeting has been served in accordance with the rules. Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended state:

‘11A.(1) Where a meeting is to be held in accordance with rule 10(3), the [Fitness to Practise] Committee shall send notice of the meeting to the registrant no later than 28 days before the date the meeting is to be held.

34.(3) Any other notice or document to be served on a person under these Rules may be sent by—
(a) ordinary post’

The panel accepted the advice of the legal assessor.

It noted that the letter of notice of this substantive meeting was sent to Mrs Phelan’s address on the register by both first class post and recorded delivery on 6 June 2019. This letter informed her that the misconduct allegations against her would be considered by a Fitness to Practise panel at a meeting on or after 8 July 2019 and invited her to provide any response or comments by 5 July 2019. The panel noted that while there was no evidence that the letter sent by recorded delivery had been signed for, there was no reason to suppose that the letter sent by first class post had not been successfully delivered. In any event the panel was satisfied that notice was sent more than 28 days in advance of this meeting and noted that the Rules do not require that notice is delivered. The panel therefore determined that there had been effective notice in accordance with the Rules.

After it had made its findings on the misconduct charges, the panel was informed that Mrs Phelan was also facing a further allegation concerning a police caution. The panel was informed that a separate notice letter had been sent to Mrs Phelan in relation to this charge.

The panel was informed that there was only one entry in the NMC’s post book, despite two notice letters having been sent. However, the panel noted that both letters were dated 6 June 2019 and it was therefore reasonable to infer that both letters had been sent together, in the same envelope.

In these circumstances, the panel was satisfied that the second notice letter had also been served more than 28 days in advance of this meeting and in accordance with the Rules.

Decision to amend charge 1(b)(ii), 1(b)(iii) and 1(h)(i)

Upon reading the bundle, the panel noticed that there was a discrepancy in some of the charges between the quantity/volume of medication alleged to have been prescribed and the quantity/volume of medication shown as being prescribed on the relevant prescriptions.

The discrepancies are summarised below:

| Charge | Quantity Alleged in Charge | Quantity Prescribed |
|---------------|---|---|
| 1(b)(i) | <u>56</u> x codeine 15mg tablets | <u>100</u> x codeine 15mg tablets |
| 1(b)(iii) | <u>8</u> x amitriptyline <u>100mg capsules</u> | <u>56</u> x amitriptyline <u>10mg tablets</u> |
| 1(h)(i) | <u>300ml</u> bottle of 10mg/5ml morphine sulphate | <u>100ml</u> bottle of 10mg/5ml morphine sulphate |

The panel considered whether to amend the charges outlined above. It accepted the advice of the legal assessor that Rule 28 of the Rules allows a panel to amend a charge

at any stage prior to making its findings of fact, provided that the amendment can be made without injustice.

The panel bore in mind that the NMC's case against Mrs Phelan was that she had inappropriately prescribed these medications. The witness evidence before the panel suggested that the prescribing of the above drugs in the context of a walk in centre was inappropriate, given their potentially serious side effects and potential for addiction. The panel therefore considered that the specific quantity which Mrs Phelan allegedly prescribed was not material to the charges.

The panel was mindful that, as these allegations are being considered at a meeting, Mrs Phelan is not in attendance and therefore cannot make representations about the proposed amendment. However, the panel considered that she had been sent the charges and the supporting evidence in advance of the hearing and was aware of the NMC's case against her. Amending the above charges as outlined above would not change the substance of the charges, nor the misconduct alleged within them. For these reasons, the panel was satisfied that the charges 1(b)(ii), 1(b)(iii) and 1(h)(i) could be amended without injustice.

Decision to amend charge 1(m)

Upon reading the bundle, the panel also noticed that there was a discrepancy between charge 1(m) and the supporting evidence.

Charge 1(m) alleges that Mrs Phelan prescribed 56 x codeine 30mg tablets and 14 x diazepam 2mg tablets to Patient N on 14 July 2017. However, the documentary evidence suggests that the medications were in fact prescribed by Mrs Phelan on 14 August 2017.

The panel considered whether to amend the charge. It accepted the advice of the legal assessor that Rule 28 of the Rules allows a panel to amend a charge at any stage prior

to making its findings of fact, provided that the amendment can be made without injustice.

The panel considered that the date in the charge was a typographical error. This was supported by the fact that charge 4 also makes allegations concerning Mrs Phelan's interaction with Patient N, but this charge refers to 14 August 2017.

The panel was mindful that, as these allegations are being considered at a meeting, Mrs Phelan is not in attendance and therefore cannot make representations about the proposed amendment. However, the panel considered that she had been sent the charges and the supporting evidence in advance of the hearing and was aware of the NMC's case against her. The proposed amendment does not change the substance of the charge, nor the misconduct it alleges. For these reasons, the panel was satisfied that the charge could be amended without injustice.

Background

The charges arose while Mrs Phelan was employed via Amber Care Agency as a Nurse Practitioner at the Battle Hill and Ponteland Road Walk in Centres. Mrs Phelan worked a number of shifts at the walk in centres between March and August 2017.

The walk in centres provided a service for minor illness and ailments. As a nurse practitioner, Mrs Phelan was responsible for seeing patients and issuing prescriptions as appropriate. However, if the presenting complaint was outside the scope of what was safe and appropriate to treat at a walk in centre, then the Nurse Practitioners were expected to re-direct patients to other services, such as their GP or A&E. The walk in centres had a triage protocol in place to identify issues and complaints which were outside the scope of the walk in centres' service. These included complaints arising out of road traffic accidents, pregnancy related complaints and any ongoing health problems which were currently being treated by the patient's GP or other health professional.

It is alleged that, on a number of occasions while working as a Nurse Practitioner at the Battle Hill and Ponteland Road Walk in Centres, Mrs Phelan prescribed various medications to patients when it was not appropriate to do so.

It is further alleged that on 8 September 2017 Mrs Phelan was cautioned by Northumbria Police in relation to obtaining medical prescriptions during working duty by committing fraud by false representation, contrary to section 2 of the Fraud Act 2006. The panel was not made aware of this allegation until after it had made its decisions in relation to the misconduct charges against Mrs Phelan.

Decision on the misconduct charges

In reaching its decisions on the facts, the panel took into account all of the documentary evidence in this case, which included two witness statements from the Team Leader at the walk in centres and extracts from patient records.

The panel accepted the advice of the legal assessor.

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

Amongst the papers provided to the panel was a letter from Mrs Phelan to the NMC, dated 3 September 2018, and an NMC case management form, received on 16 January 2019. Within these documents, Mrs Phelan appears to accept the NMC's concerns about her practice. However, she has not made any formal admissions to the specific charges against her. The panel was mindful that the burden of proof is on the NMC and, in these circumstances, decided that it would not be appropriate to take Mrs Phelan's limited comments as formal admissions to the charges.

The panel therefore considered each charge separately and made the following findings:

Charge 1(a)

That you whilst employed as a Nurse Practitioner at Ponteland Road and Battle Hill walk-in centres between March and August 2017;

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - a) On 17 August 2017 prescribed Patient B;**
 - i) Naproxen 500mg tablets**

This charge is found proved.

The panel had a copy of Patient B's electronic 'consultation information sheet' from 17 August 2017. This showed that on 17 August 2017 Patient B presented at the walk in centre with swelling and redness to his hand as the result of a wasp sting. The records show that Mrs Phelan prescribed three medications for Patient B. One of these was 56 x naproxen 500mg tablets.

According to the witness statement of Ms 1, Team Lead Nurse Practitioner at the walk in centres, when prescribing analgesia it is basic knowledge of any qualified nurse prescriber to try first line analgesics (such as paracetamol and ibuprofen) before considering anything stronger for a patient. Ms 1 also states that because a walk in centre is for the treatment of minor illness and ailments and there is no provision for ongoing monitoring of a patient, it is not normally expected that a nurse practitioner working in this environment would prescribe anything stronger than paracetamol or ibuprofen.

In relation to the prescription of naproxen for Patient B, Ms 1 states that it would be inappropriate to prescribe this in the walk in centre as it is normally given to patients who have had surgical procedures or for whom ibuprofen has been tried without effect. Ms 1 states that, if naproxen was prescribed, she would expect to see a documented justification in the patient's records as to why first line pain killers had not been tried first.

The panel could see from Patient B's records that Mrs Phelan had not documented any reason why she did not advise first line treatment instead of naproxen.

The panel was therefore satisfied that Mrs Phelan did prescribe naproxen 500mg tablets to Patient B on 17 August 2017 and that this was both clinically inappropriate to the diagnosis and inappropriate to prescribe in the context of a walk in centre.

Accordingly, charge 1(a) is found proved.

Charge 1(b)

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - b) On 19 August 2017 prescribed Patient C;**
 - i) Doxycycline 8 - 100mg capsules**
 - ii) Codeine 100 - 15mg tablets**
 - iii) Amitriptyline 56 – 10mg tablets**

This charge is found proved in its entirety.

The panel had a copy of Patient C's electronic 'consultation information sheet' from 19 August 2017. This showed that on 19 August 2017 Patient C presented at the walk in centre with left sided facial pain. The records show that Mrs Phelan prescribed 8 x

doxycycline 100mg capsules, 100 x codeine 15mg tablets and 56 x amitriptyline 10mg tablets.

The panel had regard to Ms 1's witness statement. She states that doxycycline is an antibiotic which is used to treat bacterial infections. She states that a nurse prescriber should only prescribe antibiotics if there is clear documented evidence of a bacterial infection. There was no such evidence in Patient C's notes and the panel was therefore satisfied that prescribing doxycycline was clinically inappropriate.

In relation to codeine, Ms 1 states that this is a second line analgesia and should only be prescribed in a walk in centre setting if first line analgesia has failed. If it is prescribed, then Ms 1 states that it should only be prescribed in small amounts (up to 5 days) to give the patient time to see their own GP for review. Ms 1 states that this is because codeine is an addictive drug and long term use (defined as more than a few days) needs to be monitored by a doctor. Ms 1 describes the quantity of codeine tablets prescribed by Mrs Phelan as 'a huge quantity'. She states that she would expect any qualified nurse prescriber to recognise that this quantity of codeine would have the potential for side effects such as addiction, constipation and drowsiness and that it would not be appropriate to prescribe this amount of codeine at a walk in centre. The panel accepted the evidence of Ms 1. It had regard to Patient C's notes and noted that Mrs Phelan did not document any justification for prescribing codeine instead of first line analgesia. It was therefore satisfied that Mrs Phelan's prescription of 100 x codeine 15mg tablets was both clinically inappropriate, as she did not document any justification for this, and inappropriate in the context of a walk in centre, as the centre did not have any provision to monitor a patient in receipt of such a large quantity of codeine.

In relation to amitriptyline, Ms 1 states that this is a very strong drug used for nerve pain. She states that it is addictive and can cause nightmares and affect sleep patterns. Overdoses can also cause hallucinations. Ms 1 states that amitriptyline requires ongoing monitoring and, for this reason, it is inappropriate to prescribe it in a walk in centre where there is no provision for this. Ms 1 also states that if Patient C's pain was

so severe as to require this medication then that should have been an indication that her condition was too serious to be dealt with at the walk in centre and she should have been directed to the 111 service or A&E for treatment. The panel accepted the evidence of Ms 1 and noted that Mrs Phelan had prescribed Patient C 56 x amitriptyline 10mg tablets. It was therefore satisfied that Mrs Phelan's prescription of 56 x amitriptyline 10mg tablets was both clinically inappropriate, as she did not document any justification for this, and inappropriate in the context of a walk in centre, as the centre did not have any provision to monitor a patient in receipt of such a large quantity of a strong and addictive drug.

The panel was therefore satisfied that Mrs Phelan did prescribe 8 x doxycycline 100mg capsules, 100 x codeine 15mg tablets and 56 x amitriptyline 10mg tablets to Patient C on 19 August 2017 and that these were all both clinically inappropriate to the diagnosis and inappropriate to prescribe in the context of a walk in centre.

Accordingly, charge 1b(i), (ii) and (iii) are found proved.

Charge 1(c)

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - c) On August 20 2017 prescribed Patient D;**
 - i) Codeine 56 – 15mg tablets**

This charge is found proved.

The panel noted that, in her witness statement, Ms 1 provides a list of 14 dates on which Mrs Phelan worked shifts at the work in centres. None of these were 20 August 2017. However, the panel also had a copy of Patient D's electronic 'consultation information sheet' from 20 August 2017 which shows that Mrs Phelan was logged in to the system on this date and generated a prescription for Patient D. The panel noted that

the electronic system appeared to automatically stamp all entries with the date, time and name of the user logged in to the system. The panel therefore considered that, on the balance of probabilities, it was more likely that Ms 1 had made a mistake when checking Mrs Phelan's employment history and it is was reasonable to infer that Mrs Phelan was in fact at work on 20 August 2017.

The panel had regard to Patient D's electronic records. These showed that on 20 August 2017 Mrs Phelan prescribed 56 x codeine 15mg tablets. The records provided no justification for this. The panel had regard to the evidence of Ms 1 and its earlier findings in relation to charge 1(b)(ii). It was therefore satisfied that Mrs Phelan had prescribed 56 x codeine 15mg tablets and that this was both clinically inappropriate, as she did not document any justification for this, and inappropriate in the context of a walk in centre, as the centre did not have any provision to monitor a patient in receipt of such a large quantity of codeine.

Accordingly, charge 1(c)(i) is found proved.

Charge 1(d)

1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;

d) On 9 April 2017 prescribed Patient E;

i) Codeine 28 – 15mg tablets

ii) Diazepam 6 – 2mg tablets

iii) Naproxen 56 – 500mg tablets

This charge is found proved in its entirety.

The panel had a copy of Patient E's electronic 'consultation information sheet' from 9 April 2017. This showed that on 9 April 2017 Patient E presented at the walk in centre

with neck pain. The records show that Mrs Phelan prescribed 28 x codeine 15mg tablets, 6 x diazepam 2mg tablets and 56 x naproxen 500mg tablets.

The panel had regard to Ms 1's evidence in relation to prescribing codeine at the walk in centre. The panel was satisfied that prescribing 28 x codeine 15mg tablets was both clinically inappropriate, as she did not document any justification for this, and inappropriate in the context of a walk in centre, as the centre did not have any provision to monitor a patient in receipt of such a large quantity of codeine.

In relation to diazepam, the panel accepted Ms 1's evidence that diazepam should not be prescribed at a walk in centre because it is 'highly addictive and too strong for the minor illnesses and ailments within our scope'. The panel was therefore satisfied that prescribing 6 x diazepam 2mg tablets was inappropriate in the context of a walk in centre.

The panel also had regard to Ms 1's evidence in relation to naproxen. It accepted her evidence that this is a second line analgesic and she would not expect this to be prescribed without a documented clinical justification as to why first line pain killers, such as paracetamol or ibuprofen, were not being tried first. Ms 1 also stated that the quantity prescribed by Mrs Phelan for Patient E was concerning. Mrs Phelan had prescribed a months' supply. According to Ms 1, if a patient is experiencing pain for that length of time then they should be advised to visit their GP as it could be an indication of a chronic condition. The panel could see no clinical justification recorded in Patient E's notes as to why Mrs Phelan prescribed naproxen instead of ibuprofen or paracetamol. There was also no documented advice to the patient regarding seeing their GP. The panel was therefore satisfied that prescribing 56 x naproxen 500mg tablets was both clinically inappropriate to the diagnosis and inappropriate to prescribe in the context of a walk in centre.

Accordingly, charges 1(d)(i), (ii) and (iii) are found proved.

Charge 1(e)

1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;

e) On 22 April 2017 prescribed patient F;

i) Diazepam 14 – 2mg tablets

ii) Gabapentin 100 – 100mg capsules

iii) Naproxen 56 – 500mg tablets

This charge is found proved in its entirety.

The panel had a copy of Patient F's electronic 'consultation information sheet' from 22 April 2017. This showed that on 22 April 2017 Patient F presented at the walk in centre with shoulder pain. The records show that Mrs Phelan prescribed 14 x diazepam 2mg tablets, 100 x gabapentin 100mg capsules and 56 x naproxen 500mg tablets.

The panel had regard to Ms 1's evidence in relation to prescribing diazepam at the walk in centre and its earlier findings in relation to charge 1(d)(ii). The panel was therefore satisfied that prescribing 14 x diazepam 2mg tablets was inappropriate in the context of a walk in centre for the same reasons.

The panel also had regard to Ms 1's evidence in relation to prescribing gabapentin at the walk in centre. She states that it would be inappropriate to prescribe this drug at a walk in centre as it requires ongoing monitoring due to its potentially significant side effects. In addition, Patient F presented at the walk in centre having experienced pain for only one day, and yet Mrs Phelan prescribed him a month's supply of gabapentin. The panel was therefore satisfied that prescribing 100 x gabapentin 100mg capsules was both clinically inappropriate, as Patient F had only been experiencing pain for a day, and inappropriate in the context of a walk in centre, as the centre did not have any provision to monitor a patient in receipt of such a large quantity of gabapentin.

In relation to naproxen, the panel had regard to the evidence of Ms 1 and its earlier findings in relation to charge 1(a)(i), 1(d)(iii) and 1(e)(iii). It noted that there was no documented reason in Patient F's notes as to why Mrs Phelan had prescribed naproxen instead of ibuprofen or paracetamol. The panel was therefore satisfied that prescribing 56 x naproxen 500mg tablets was both clinically inappropriate to the diagnosis and inappropriate to prescribe in the context of a walk in centre.

Accordingly, charges 1(e)(i), (ii) and (iii) are found proved.

Charge 1(f)

1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;

f) On 22 May 2017 prescribed patient G;

i) Amitriptyline 28 – 25mg tablets

ii) Diazepam 9 – 2mg tablets

This charge is found proved in its entirety.

The panel noted that, in her witness statement, Ms 1 provides a list of 14 dates on which Mrs Phelan worked shifts at the work in centres. None of these were 22 May 2017. However, the panel also had a copy of Patient G's electronic 'consultation information sheet' from 22 May 2017 which shows that Mrs Phelan was logged in to the system on this date and generated a prescription for Patient G. The panel noted that the electronic system appeared to automatically stamp all entries with the date, time and name of the user logged in to the system. The panel therefore considered that, on the balance of probabilities, it was more likely that Ms 1 had made a mistake when checking Mrs Phelan's employment history and it is reasonable to infer that Mrs Phelan was in fact at work on 22 May 2017.

Patient G's electronic records showed that on 22 May 2017 Patient G presented at the walk in centre with shoulder pain. The records show that Mrs Phelan prescribed 28 x amitriptyline 25mg tablets and 9 x diazepam 2mg tablets.

The panel had regard to the evidence of Ms 1. In her witness statement, she states that neither of these drugs would be appropriate to start at a walk in centre, as both require ongoing monitoring. Furthermore, she states that the normal starting dose for amitriptyline is 10mg, significantly lower than the 25mg dose prescribed by Mrs Phelan. Mrs Phelan also prescribed a month's supply of amitriptyline, despite the walk in centre having no provision for the ongoing monitoring of patients.

For these reasons, the panel was satisfied that Mrs Phelan prescribed 28 x amitriptyline 25mg tablets and 9 x diazepam 2mg tablets for Patient G on 22 May 2017 and that the prescription of both of these medications was both clinically inappropriate and inappropriate in the context of a walk in centre.

Accordingly, charge 1(f)(i) and (ii) are found proved.

Charge 1(g)

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - g) On 28 June 2017 prescribed and/or generated a prescription for patient H, for;**
 - i) Diazepam 14 – 2mg tablets**
 - ii) 300ml bottle of 10mg/5m Morphine Sulphate**

This charge is found proved in its entirety.

The panel had a copy of Patient H's electronic 'consultation information sheet' from 28 June 2017. This showed that on 28 June 2017 Patient H presented at the walk in centre

with lower back pain. The records show that Mrs Phelan prescribed 14 x diazepam 2mg tablets and a 300ml bottle of 10mg/5ml morphine sulphate.

The panel was satisfied, for the reasons already given, that it was inappropriate to prescribe diazepam in the context of a walk in centre.

In relation to the morphine sulphate, the panel had regard to the evidence of Ms 1. According to Ms 1, morphine sulphate is a very strong and highly addictive controlled drug and there are no circumstances in which a nurse practitioner should prescribe this in a walk in centre. The use of the drug requires careful monitoring and could indicate a more serious or chronic underlying problem which would be outside the scope of the walk in centre. The panel was therefore satisfied that prescribing a 300ml bottle of 10mg/5ml morphine sulphate to Patient H was both clinically inappropriate to the patient's diagnosis and inappropriate in the context of a walk in centre.

Accordingly, charges 1(g)(i) and (ii) are found proved.

Charge 1(h)

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - h) On 28 June 2017 prescribed a 100ml bottle of 10mg/5ml Morphine Sulphate to Patient I;**

This charge is found proved.

The panel had a copy of Patient I's electronic 'consultation information sheet' from 28 June 2017. This showed that on 28 June 2017 Patient I presented at the walk in centre with left foot pain. The records show that Mrs Phelan prescribed a 100ml bottle of 10mg/5ml morphine sulphate.

The panel was satisfied, for the reasons already given, that prescribing morphine sulphate to Patient I was both clinically inappropriate to the patient's diagnosis and inappropriate in the context of a walk in centre, for the reasons already given in charge 1(g).

Accordingly, charge 1(h) is found proved.

Charge 1(i)

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - i) On 28 June 2017 prescribed Patient J;**
 - i) Diazepam 9 – 2mg tablets**
 - ii) Codeine 32 – 30mg tablets**

This charge is found proved.

The panel had a copy of Patient J's electronic 'consultation information sheet' from 28 June 2017. This showed that on 28 June 2017 Patient J presented at the walk in centre with pain caused by a seatbelt injury, sustained during a road traffic accident. The records show that Mrs Phelan prescribed 9 x diazepam 2mg tablets and 32 x codeine 30mg tablets.

The panel was satisfied, for the reasons given in earlier charges, that both the diazepam and the codeine were clinically inappropriate, as they were not first line analgesic drugs. Furthermore, they were inappropriate in the context of a walk in centre as the quantities prescribed would require ongoing monitoring.

Accordingly, charges 1(i)(i) and (ii) are found proved.

Charge 1(j)

1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;

j) On 4 July 2017 prescribed and/or generated a prescription for Patient K, for;

i) Codeine 56 – 15mg tablets

ii) 500ml bottle of 10mg/5ml Morphine Sulphate

This charge is found proved.

The panel had a copy of Patient K's electronic 'consultation information sheet' from 4 July 2017. This showed that on 4 July 2017 Patient K presented at the walk in centre with right knee pain. The records show that Mrs Phelan prescribed 56 x codeine 15mg tablets. It also showed that she generated a prescription for a 500ml bottle of 10mg/5ml morphine sulphate, but later deleted it.

The panel was satisfied, for the reasons given in earlier charges, that prescribing codeine was clinically inappropriate, as it is not a first line analgesic drug, and was also inappropriate in the context of a walk in centre as the quantity prescribed would require ongoing monitoring.

As regards the morphine sulphate, the panel noted that Mrs Phelan did generate a prescription for a 500ml bottle of morphine sulphate, albeit that she later deleted it. The panel had regard to its earlier reasons and the evidence of Ms 1 that it would always be inappropriate to prescribe morphine sulphate in a walk in centre due to it being a highly addictive controlled drug which requires close monitoring. Taking this into account, the panel was satisfied that on 4 July 2017 Mrs Phelan generated a prescription for a 500ml bottle of 10mg/5ml morphine sulphate and that this was both clinically inappropriate and inappropriate in the context of a walk in centre.

Accordingly, the charges 1(j)(i) and 1(j)(ii) are found proved.

Charge 1(k)

1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;

k) On 9 July 2017 prescribed for Patient L;

i) Codeine 56 – 30mg tablets

ii) 500ml bottle of 10mg/5ml Morphine Sulphate

Charge 1(k)(i) is found proved. Charge 1(k)(ii) is found NOT proved.

The panel noted that, in her witness statement, Ms 1 provides a list of 14 dates on which Mrs Phelan worked shifts at the work in centres. None of these were 9 July 2017. However, the panel also had a copy of Patient L's electronic 'consultation information sheet' from 9 July 2017 which shows that Mrs Phelan was logged in to the system on this date and had a consultation with Patient L. The panel noted that the electronic system appeared to automatically stamp all entries with the date, time and name of the user logged in to the system. The panel therefore considered that, on the balance of probabilities, it was more likely that Ms 1 had made a mistake when checking Mrs Phelan's employment history and it is was reasonable to infer that Mrs Phelan was in fact at work on 9 July 2017.

The panel had regard to Patient L's electronic records from 9 July 2017. These showed that on 9 July 2017 Patient L presented at the walk in centre with lung/chest pain. The records show that Mrs Phelan prescribed 56 x codeine 30mg tablets. It also showed that she generated a prescription for a 500ml bottle of 10mg/5ml morphine sulphate by printing it out even though she recorded she had deleted it.

The panel was satisfied, for the reasons given in earlier charges, that prescribing codeine was clinically inappropriate, as it is not first line analgesic drug, and was also

inappropriate in the context of a walk in centre as the quantity prescribed would require ongoing monitoring.

As regards the morphine sulphate, the panel noted that Mrs Phelan did generate a prescription for a 500ml bottle of morphine sulphate, but she later deleted it. The panel therefore had no evidence that Mrs Phelan actually prescribed morphine sulphate to Patient L on 9 July 2019. Unlike charge 1(j), charge 1(k) is not worded as 'prescribed and/or generated a prescription'. It only alleges that Mrs Phelan prescribed the medication. In these circumstances, the panel found this part of the charge not proved.

Accordingly, charge 1(k)(i) is found proved but charge 1(k)(ii) is found not proved.

Charge 1(l)

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - l) On 9 July 2017 prescribed Patient M, for;**
 - i) Codeine 56 – 15mg tablets**
 - ii) Diazepam 6 – 2mg tablets**

The panel noted that, in her witness statement, Ms 1 provides a list of 14 dates on which Mrs Phelan worked shifts at the work in centres. None of these were 9 July 2017. However, the panel also had a copy of Patient M's electronic 'consultation information sheet' from 9 July 2017 which shows that Mrs Phelan was logged in to the system on this date and had a consultation with Patient M. The panel noted that the electronic system appeared to automatically stamp all entries with the date, time and name of the user logged in to the system. The panel therefore considered that, on the balance of probabilities, it was more likely that Ms 1 had made a mistake when checking Mrs Phelan's employment history and it is was reasonable to infer that Mrs Phelan was in fact at work on 9 July 2017.

The panel had regard to Patient M's electronic records from 9 July 2017. These showed that on 9 July 2017 Patient M presented at the walk in centre with neck pain sustained during a road traffic accident. The records show that Mrs Phelan prescribed 56 x codeine 15mg tablets and 6 x diazepam 2mg tablets.

The panel was satisfied, for the reasons given in earlier charges, that both the codeine and the diazepam were clinically inappropriate, as they were not first line analgesic drugs. Furthermore, they were inappropriate in the context of a walk in centre as the quantities prescribed would require ongoing monitoring.

Accordingly, charges 1(l)(i) and (ii) are found proved.

Charge 1(m)

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - m) On 14 August 2017 prescribed Patient N;**
 - i) Codeine 56 – 30mg tablets**
 - ii) Diazepam 14 – 2mg tablets**

This charge is found proved.

The panel had a copy of Patient N's electronic 'consultation information sheet' from 14 August 2017. This showed that on 14 August 2017 Patient N presented at the walk in centre with lower back pain. The records show that Mrs Phelan prescribed 56 x codeine 30mg tablets and 14 x diazepam 2mg tablets.

The panel was satisfied, for the reasons given in earlier charges, that both the codeine and the diazepam were clinically inappropriate, as they were not first line analgesic drugs. Furthermore, they were inappropriate in the context of a walk in centre as the quantities prescribed would require ongoing monitoring.

Accordingly, charges 1(m)(i) and (ii) are found proved.

Charge 1(n)

- 1) Prescribed medicine to patients which was clinically inappropriate to the diagnosis and history you documented and/ or was inappropriate to prescribe in the context of a walk in centre, in that you;**
 - n) On 14 August 2017 prescribed and/or generated a prescription for Patient O, for;**
 - i) 500 ml bottle of 10mg/5ml Morphine Sulphate**

This charge is found proved.

The panel had a copy of Patient O's electronic 'consultation information sheet' from 14 August 2017. This showed that on 14 August 2017 Patient O presented at the walk in centre with tonsillitis. The records show that Mrs Phelan generated a prescription for a 500ml bottle of 10mg/5ml morphine sulphate by printing it out even though the records show that she later deleted it.

The panel had regard to its earlier reasons and the evidence of Ms 1 that it would always be inappropriate to prescribe morphine sulphate in a walk in centre due to it being a highly addictive controlled drug which requires close monitoring. Taking this into account, the panel was satisfied that on 14 August 2017 Mrs Phelan generated a prescription for a 500ml bottle of 10mg/5ml morphine sulphate and that this was both clinically inappropriate and inappropriate in the context of a walk in centre.

Accordingly, charge 1(n)(i) is found proved.

Charge 2

- 2) On 28 June 2017 inappropriately conducted a consultation with Patient J who had been involved in a road traffic accident.**

This charge is found proved.

The panel had a copy of Patient J's electronic 'consultation information sheet' from 28 June 2017. This showed that on 28 June 2017 Patient J presented at the walk in centre with pain caused by a seatbelt injury, sustained during a road traffic accident. The records show that Mrs Phelan prescribed 9 x diazepam 2mg tablets and 32 x codeine 30mg tablets.

The panel had regard to the Battle Hill and Ponteland Road 'Triage Protocol'. This protocol makes it clear that nurse practitioners at the walk in centre are not able to treat, assess or deal with patients who attend with complaints arising out of a road traffic accident. This is confirmed by Ms 1 in her witness statement.

The panel was therefore satisfied that on 28 June 2017 Mrs Phelan inappropriately conducted a consultation with Patient J who had been involved in a road traffic accident.

Accordingly, charge 2 is found proved.

Charge 3

- 3) On 9 July 2017 inappropriately conducted a consultation with Patient M who had been involved in a road traffic accident.**

This charge is found proved.

The panel had a copy of Patient M's electronic 'consultation information sheet' from 9 July 2017. This showed that on 9 July 2017 Patient M presented at the walk in centre with neck pain sustained during a road traffic accident. The records show that Mrs Phelan prescribed 56 x codeine 15mg tablets and 6 x diazepam 2mg tablets.

The panel had regard to the Battle Hill and Ponteland Road 'Triage Protocol'. This protocol makes it clear that nurse practitioners at the walk in centre are not able to treat, assess or deal with patients who attend with complaints arising out of a road traffic accident. This is confirmed by Ms 1 in her witness statement.

The panel was therefore satisfied that on 9 July 2017 Mrs Phelan inappropriately conducted a consultation with Patient M who had been involved in a road traffic accident.

Accordingly, charge 3 is found proved.

Charge 4

- 4) On 14 August 2017 inappropriately conducted a consultation with Patient N who was experiencing symptoms of a chronic and ongoing condition for which they were already receiving treatment.**

This charge is found proved.

The panel had a copy of Patient N's electronic 'consultation information sheet' from 14 August 2017. This showed that on 14 August 2017 Patient N presented at the walk in centre with lower back pain, which was being treated by a physiotherapist. The records show that Mrs Phelan prescribed 56 x codeine 30mg tablets and 14 x diazepam 2mg tablets.

The panel had regard to the Battle Hill and Ponteland Road 'Triage Protocol'. This protocol makes it clear that nurse practitioners at the walk in centre are not able to treat, assess or deal with patients who attend with complex or ongoing medical conditions. This is confirmed by Ms 1 in her witness statement.

The panel was therefore satisfied that on 14 August 2017 Mrs Phelan inappropriately conducted a consultation with Patient N who was experiencing symptoms of a chronic and ongoing condition for which they were already receiving treatment.

Accordingly, charge 4 is found proved.

Charge 5

5) On 14 August 2017 did not refer Patient N back to her GP or treating specialist.

This charge is found proved.

The panel had a copy of Patient N's electronic 'consultation information sheet' from 14 August 2017. This showed that on 14 August 2017 Patient N presented at the walk in centre with lower back pain, which was being treated by a physiotherapist. The records show that Mrs Phelan prescribed 56 x codeine 30mg tablets and 14 x diazepam 2mg tablets.

The panel had regard to the Battle Hill and Ponteland Road 'Triage Protocol'. This protocol makes it clear that nurse practitioners at the walk in centre are not able to treat, assess or deal with patients who attend with complex or ongoing medical conditions. In her witness statement, Ms 1 confirms that Patient N should have been referred back to her GP or advised to seek an earlier physiotherapy appointment for her back pain. There is no evidence in Patient N's records that Mrs Phelan made such recommendations.

The panel was therefore satisfied that on 14 August 2017 Mrs Phelan did not refer Patient N back to her GP or treating specialist.

Accordingly, charge 5 is found proved.

Charge 6

- 6) On 14 August 2017 inappropriately conducted a consultation with Patient P who was exhibiting pregnancy related symptoms**

This charge is found proved.

The panel had a copy of Patient P's electronic 'consultation information sheet' from 14 August 2017. This showed that on 14 August 2017 Patient P presented at the walk in centre with abdominal pain and other symptoms which indicated a possible ectopic pregnancy. The records show that she was seen by Mrs Phelan.

The panel had regard to the Battle Hill and Ponteland Road 'Triage Protocol'. This protocol makes it clear that nurse practitioners at the walk in centre are not able to treat, assess or deal with patients who attend with any pregnancy related issues. This is confirmed by Ms 1 in her witness statement.

The panel was therefore satisfied that on 14 August 2017 Mrs Phelan inappropriately conducted a consultation with Patient P who was exhibiting pregnancy related symptoms.

Accordingly, charge 6 is found proved.

Charge 7

- 7) On 14 August did not refer Patient P to a Gynaecology department.**

This charge is found proved.

The panel had a copy of Patient P's electronic 'consultation information sheet' from 14 August 2017. This showed that on 14 August 2017 Patient P presented at the walk in centre with abdominal pain and other symptoms which indicated a possible ectopic

pregnancy. The records show that she was seen by Mrs Phelan but there is nothing documented to suggest that she referred Patient P on to a gynaecology department.

The panel was therefore satisfied that on 14 August 2017 Mrs Phelan did not refer Patient P to a gynaecology department.

Accordingly, charge 7 is found proved.

Decision on caution charge

Having made its findings of fact on the misconduct charges, the panel was informed that Mrs Phelan also faces an additional charge, namely:

That you a registered nurse,

- 1. On the 8th of September 2017 were cautioned by Northumbria Police as you “Between 1 August – 28 August 2017 obtained medical prescriptions during working duty committing fraud by false representation,” contrary to section 2 of the Fraud Act 2006.**

The panel was provided with a second bundle of documents relating to this charge. This included a signed caution form, signed by Mrs Phelan on 8 September 2017. The offence detailed on the caution was ‘Between 1 August – 28 August obtained medical prescriptions during working duty committing fraud by false representation’.

The panel also had regard to a transcript of a police interview conducted with Mrs Phelan on 2 September 2017. In this interview, Mrs Phelan admitted that, on four occasions, she had generated prescriptions for morphine sulphate at work, printed them, and then deleted them from the system as having been created in error. Mrs Phelan admitted then using these prescriptions to obtain morphine for her own use.

Taking all of the above into account, the panel was satisfied that on 8 September 2017 Mrs Phelan was cautioned by Northumbria Police as she 'Between 1 August – 28 August 2017 obtained medical prescriptions during working duty committing fraud by false representation,' contrary to section 2 of the Fraud Act 2006.

Accordingly, this charge is found proved.

Decision on misconduct and impairment

Having made its finding on the charges, the panel then moved on to consider whether the facts found proved at charges 1 – 6 amounted to misconduct.

When making its decision, the panel had regard to the advice of the legal assessor and the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"). It also had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Mrs Phelan's actions at charges 1 – 6 fell significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically:

'8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely, and

18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship.

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

20.4 keep to the laws of the country in which you are practising'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Phelan's actions constituted a sustained pattern of inappropriate prescribing over a six month period of time, which fell seriously short of the standards expected of a registered nurse prescriber. On numerous occasions Mrs Phelan failed to adhere to the walk in centres' guidelines regarding prescribing, and prescribed large quantities of strong and addictive medications to patients in a setting where there was no facility to monitor their ongoing use of these drugs. Furthermore, Mrs Phelan assessed and prescribed for patients who

were not suitable to be seen at the walk in centres and failed to signpost them to the appropriate healthcare practitioner for their needs. The panel considered that all of these actions had the potential to put patients at serious risk of harm and amounted to misconduct.

Decision on impairment

Having decided that the facts found proved at charges 1 – 6 do amount to misconduct, the panel moved on to consider whether Mrs Phelan's fitness to practise is currently impaired as a result of that misconduct and her police caution. There is no statutory definition of fitness to practise however the NMC has defined it as a registrant's suitability to remain on the register unrestricted.

Nurses occupy a position of privilege and trust in society. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) in reaching its decision, in paragraph 74 she said:

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

Mrs Justice Cox went on to say in Paragraph 76:

'I would also add the following observations in this case...as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

- a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
- b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
- c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
- d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel found that all four limbs of the Grant test were engaged in this case. Mrs Phelan's prescribing practices had put patients at a risk of harm. By using prescriptions to obtain morphine sulphate for her own benefit she had acted dishonestly. Her misconduct and police caution together breached fundamental tenets of the profession and brought it into disrepute.

The panel then moved onto consider whether Mrs Phelan was likely to repeat such actions in the future.

The only information that the panel had from Mrs Phelan regarding the allegations against her was a letter from her, dated 3 September 2018, and a handwritten response on an NMC case management form which was received on 16 January 2019. In her letter dated 3 September 2018 Mrs Phelan refused to comply with medical testing, writing that she understood that this decision 'will ultimately result in being struck off the nursing register which I regret but [PRIVATE]'.

In her response received on 19 January 2019 Mrs Phelan outlines a number of health issues that she was experiencing at the time and writes that [PRIVATE].

These explanations were consistent with the personal mitigation which she gave to the police regarding her health and family situation at the time. However, the panel had no independent evidence regarding Mrs Phelan's health at the time, nor any information regarding how it had specifically impacted on her actions and decisions. Although Mrs Phelan had offered her health as motivation to the police for obtaining morphine sulphate by false representation, the panel was of the view that this did not explain the numerous other prescribing issues which did not appear to be for her own personal gain.

The panel acknowledged that Mrs Phelan has expressed remorse for her actions. She also made early admissions to the police and accepted the NMC's regulatory concerns regarding her practice. However, the panel had no evidence of any remediation. It also considered that Mrs Phelan had demonstrated very limited insight into her actions.

In these circumstances, the panel concluded that there was a real risk of repetition and, consequently, a real risk of future patient harm. The panel therefore decided that a finding of impairment was necessary on the grounds of public protection.

The panel also bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel therefore determined that, in this case, a finding of impairment on public interest grounds was also required. Mrs Phelan abused her position as a qualified nurse prescriber to obtain medication for herself. She abused the trust placed in her by her employer and patients and failed to demonstrate the values of honesty, integrity and probity which are required and expected of all registered nurses. The panel considered that, in these circumstances, the public would expect a finding of current impairment to be made.

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

Determination on sanction

The panel considered this case and decided to make a striking-off order. The effect of this order is that the NMC register will show that Mrs Phelan has been struck-off the register.

In reaching this decision, the panel had regard to the advice of the legal assessor who referred it to Atkinson v GMC [2009] EWHC 3636 (Admin) and The Queen on the application of Hassan v GOC [2013] EWHC 1887 (Admin). It bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel considered that the aggravating factors in this case were:

- Mrs Phelan abused her position of trust;
- her actions had the potential to cause serious patient harm;
- her actions constitute a pattern of misconduct over a period of time.

The panel considered that the mitigating factors in this case were:

- Mrs Phelan made early admissions to the police, acknowledged that she had been dishonest and accepted the NMC's regulatory concerns.

The panel also noted that Mrs Phelan provided some limited evidence of difficult personal circumstances and her own health issues at the time, which may have motivated her to dishonestly obtain morphine. However, the panel had no independent evidence to support this and was not satisfied that it offered an explanation for the other numerous prescribing issues, which did not appear to be for her personal gain. The panel therefore attached limited weight to this personal mitigation.

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the Sanctions Guidance, which 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 Phelan'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 Phelan's registration would be a sufficient and appropriate response. The panel bore in mind that

Mrs Phelan has demonstrated no insight and no remediation. She also deliberately abused her position as a nurse prescriber for her own benefit and put patients at serious risk of harm. The panel did not consider that the concerns regarding Mrs Phelan's practice could be addressed with conditions. It was also of the view that a conditions of practice order would not be sufficient to uphold the public interest, given the seriousness of this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The Sanctions Guidance indicates that a suspension order would be appropriate where:

'...the misconduct is not fundamentally incompatible with continuing to be a registered nurse or midwife in that the public interest can be satisfied by a less severe outcome than permanent removal from the register. This is more likely to be the case when some or all of the following factors are apparent (this list is not exhaustive):

- 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
- ...
- ...'

The panel considered that Mrs Phelan's actions could not be characterised as a single instance of misconduct; she had inappropriately prescribed strong and addictive medications on several occasions over a period of six months. She also abused her position as a nurse prescriber and prioritised her own needs over the standards of professional conduct expected of her, which the panel considered was indicative of an

attitudinal problem. Although the panel had no evidence of repetition of this behaviour since the incident, it is also unaware of whether Mrs Phelan is still working as a registered nurse. The panel was also not satisfied that Mrs Phelan has demonstrated any insight into her behaviour and it had already decided that there was a real risk of repetition.

The panel therefore determined that a suspension order would not be an appropriate or proportionate sanction, and moved on to consider a striking-off order. It had regard to the following sections of the Sanctions Guidance:

'Key considerations are:

- can public confidence in the professions and the NMC 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 the public interest?
- is the seriousness of the case incompatible with ongoing registration (see above for the factors to take into account when considering seriousness)?

This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional, which may involve any of the following factors.

- A serious departure from the relevant professional standards as set out in key standards, guidance and advice.
- Doing harm to others or behaving in such a way that could foreseeably result in harm to others, particularly patients or other people the nurse or midwife comes into contact with in a professional capacity. Harm is relevant to this question whether it was caused deliberately, recklessly, negligently or through incompetence, particularly where there is a continuing risk to

patients. Harm may include physical, emotional and financial harm. The seriousness of the harm should always be considered.

- Abuse of position, abuse of trust, ...
- ...
-
- Dishonesty...
- Persistent lack of insight into seriousness of actions or consequences.
- Convictions or cautions involving any of the conduct or behaviour in the above examples.

The panel considered that Mrs Phelan's actions were a serious departure from the standards expected of a registered nurse. She failed to apply the knowledge of a nurse prescriber and adhere to the walk in centres' protocols and, as a result, placed patients at risk of serious harm. She has demonstrated a lack of insight into her conduct and brought the profession into disrepute by receiving a police caution for an offence which not only occurred in the context of her professional life, but also brings into question her honesty and integrity.

The panel had regard to the nature of Mrs Phelan's dishonesty and concluded that it was at the more serious end of the spectrum. Mrs Phelan, on at least four occasions, falsely prescribed morphine sulphate for patients at the walk in centres, in order to use the prescriptions to obtain medication for her own use. In doing so, she abused her position as a nurse prescriber and breached the trust of her employer. She also placed patients at a risk of harm.

The panel considered that the scale and scope of the prescribing issues in this case, taken together with Mrs Phelan's decision to act dishonestly and abuse her position for personal gain, raise fundamental questions about her professionalism and suitability to be on the register. Nurses are expected to act with honesty and integrity at all times, and make the safety and well-being of patients their first priority. Mrs Phelan has

repeatedly failed to do this. Furthermore, she has demonstrated no insight into her behaviour and made no attempts to remedy her conduct.

In these circumstances, the panel decided that Mrs Phelan's actions were fundamentally incompatible with ongoing registration. It considered that to continue to allow her to practise, in light of the panel's findings, would undermine confidence in the nursing profession and in the NMC as a regulator. It therefore concluded that the only sanction which would protect the public and satisfy the public interest was a striking-off order. 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.

Determination on interim order

Having made a striking-off order, the panel then considered whether it should make an interim order to cover the statutory 28 day appeal period.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to its finding of current impairment and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To not make an interim order at this stage would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.