Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

10 – 14 June 2019 & 4 - 5 November 2019 & 7 – 11 November 2019

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

Name of registrant:	Louisa Campbell
NMC PIN:	98I0665E
Part(s) of the register:	Registered Adult Nurse (12 November 2004)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Graham Park (Chair, lay member) Tanya Tordoff (Registrant member) Peter Swain (Lay member)
Legal Assessor:	Jeremy Barnett
Panel Secretary:	Kelly O'Brien
Registrant:	Ms Campbell Present and represented by Alex Jamieson, instructed by Royal College of Nursing (RCN)
Nursing and Midwifery Council:	Represented by Aimee Stokes, Case Presenter, instructed by NMC Legal Team
Facts proved:	1, 3, 5a), 5b)
Facts proved by admission:	2, 4, 6, 7, 8a), 8b)
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim Order:	Suspension order (18 months)

Details of charge

That you, a registered nurse whilst working in a British Transport Police custody suite:

1) On 9 April 2017, failed to obtain authorisation to administer diazepam to Patient B before administering such **[proved]**

2) On 9 April 2017, signed a Diazepam Medication Administration Record indicating that you had obtained authorisation to administer the drug **[admitted]**

3) On 9 April 2017, failed to obtain authorisation to administer dihydrocodeine to Patient B before administering such **[proved]**

4) On 9 April 2017, signed a Dihydrocodeine Medication Administration Record indicating that you had obtained authorisation to administer the drug **[admitted]**

5) And your actions specified in charges 2 and 4 were dishonest in that:
a) You knew that you had not obtained authorisation **[proved]**
b) You knew that it was wrong to give the misleading impression that you had obtained authorisation to administer the drugs **[proved]**

6) On 29 July 2017, at around 14.30 failed to administer gabapentin to Patient A **[admitted]**

7) On 29 July 2017, signed Patient A's notes indicating that you had administered gabapentin at 14.30 **[admitted]**

8) And your action specified in charge 7 was dishonest in that:
a) You knew that you had not administered gabapentin at 14.30 **[admitted]**
b) You knew that it was wrong to give the misleading impression that you had administered the drug at 14.30 **[admitted]**

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

Application for Mr 4 to give evidence via video link

Ms Stokes made an application to allow Mr 4 to provide his evidence via video link. Ms Stokes informed the panel that there are two witnesses listed for day 2 of this hearing and that it is unlikely that this evidence would use the entirety of the day. Ms Stokes said that Mr 4 was unable to attend day 2 of the hearing due to childcare commitments, and accordingly arrangements have been made for him to attend in person on day 3. However, Ms Stokes informed the panel that Mr 4 was able to give evidence on day 2 via video link.

Ms Stokes submitted that it would not cause any prejudice to you to hear Mr 4's evidence via video link.

Mr Jamieson did not object to the application, and submitted that it would not cause any prejudice to you to hear Mr 4's evidence via video link. He submitted that Mr 4's evidence was not contentious on matters of fact.

Panel decision

The panel decided to allow the application for Mr 4 to give evidence by way of video link. The panel considered that this was an unopposed application intended to assist with the expeditious disposal of this hearing. The panel noted that the starting point is always that live evidence is the best evidence, however it considered that it could still assess Mr 4's demeanour via video link. The panel noted that it had been assured that Mr 4 would have hard copies of his witness statement and exhibits in front of him. It also noted that Mr 4 was not a contentious witness.

Application pursuant to Rule 31

Preliminary issue and application to adjourn

Ms Stokes informed the panel that the NMC intended to make an application to include the first paragraph of Dr 7's statement. She informed the panel that an issue has arisen as Mr Jamieson has called into question whether the CCTV evidence, which is no longer available, is in fact of the events cited in the charges.

Ms Stokes informed the panel that it is the NMC's case that the CCTV relates to the correct detainee and time period, and that there is documentary evidence to support this which the NMC seek to put before the panel. She informed the panel that you had previously been served with this evidence. She submitted that it is a short piece of evidence, it consists of a single paragraph within a statement. Ms Stokes submitted that the evidence relates to a key issue in this case, namely the validity of the CCTV evidence.

Ms Stokes said that she was in a position to make the Rule 31 application now, and that Mr Jamieson had been informed that she intended to make this application earlier this morning.

Mr Jamieson informed the panel that he opposed the application to admit hearsay evidence pursuant to Rule 31. He submitted that this is a key and important issue in this case.

Mr Jamieson submitted that he would not be able to confidently discharge his professional duty to his client without being granted sufficient time to prepare his response to the application. He requested the rest of the day to prepare a written skeleton argument.

Mr Jamieson submitted that the reason he requires time is because the NMC seeks to rely on hearsay evidence to establish that the CCTV is of the place and time relevant to the charge. This is likely to be highly relevant. It is the defence's case that you have never seen the CCTV footage, despite your request, and that you dispute the findings of those who have reviewed it.

Mr Jamieson submitted that it is important that the panel follow the correct process and procedure regarding the admission of evidence, and referred the panel to the case of *El Karout -v- The Nursing and Midwifery Council [2019] EWHC 28 (Admin).*

Ms Stokes opposed the application to adjourn for the remainder of the day. She submitted that two witnesses had attended to give evidence today and it is not known whether they can be rescheduled. She further submitted that written skeletons were not necessary and that she was prepared to make her application presently.

The panel accepted the advice of the legal assessor on the issue of adjournments.

Panel decision

The panel decided to adjourn proceedings for the remainder of the day to afford Mr Jamieson time to prepare his submissions regarding the Rule 31 application. In reaching this decision the panel balanced fairness to you, fairness to the NMC, fairness to the witnesses, and the expeditious disposal of this hearing. It bore in mind that two witnesses had attended today to give live evidence and would need to be rescheduled. However, it balanced this with your right to a fair hearing. The panel considered that the admissibility of the proposed evidence was a highly contentious issue and considered that it was appropriate and proportionate to afford reasonable time to defence counsel to prepare a skeleton argument.

Accordingly, the panel decided to adjourn until 9am on 12 June 2019. The panel directed that parties must exchange written skeleton arguments in advance of the hearing resuming tomorrow and provide the panel with hard copies by 8.30am.

Application pursuant to Rule 31

The panel were provided with a copy of SJ/5 and written skeleton arguments from both Ms Stokes and Mr Jamieson, in summary:

Ms Stokes submitted that this is an application made on behalf of the NMC under Rule 31 to allow part of the Investigation Report of Dr 7 (SJ/5) into evidence. This application has come to light as a result of the defence's suggestion that Dr 1 may not have viewed the relevant footage of Patient A, during evidence on 10th June 2019.

Ms Stokes submitted that the issue to be determined at this stage is one of admissibility based on the fairness principles. The issue of how much weight is to be placed on this evidence once admitted is a matter for the panel and should be considered as separate to its admissibility.

Ms Stokes referred the panel to the cases of *Ogbonna v Nursing and Midwifery Council [2010] EWCA Civ 1216, Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin),* and *El Karout v Nursing and Midwifery Council [2019] EWHC 28 (Admin).* She submitted that it is fair and relevant to admit the evidence for the following reasons:

- The issue of the veracity of the CCTV has not been raised until day 1 of the hearing.
- The evidence of Dr 1 should be looked at in the context of the hearsay evidence of Dr 7 and Mr 6.

- The evidence which is sought to be admitted goes to the continuity of evidence in this case and the issue in whether the footage viewed was the footage of Patient A.
- the NMC did not have prior notice that the evidence would be necessary as the continuity of the evidence was not in dispute This was not identified as an issue prior to the start of this case and accordingly no steps have been taken to secure the attendance of Dr 7 or Mr 6.
- There will be no greater problems or prejudice caused to the registrant than already present for the NMC who are currently unable to rebut a suggestion to which there is supporting evidence for. At present, the evidence left how it is, is prejudicial to the NMC.

Mr Jamieson opposed the application. He submitted that the NMC is seeking to admit before the panel a document (exhibit SJ/5) which they had previously agreed ought not to be adduced.

Mr Jamieson referred the panel to the following cases *Ogbonna v Nursing and Midwifery Council [2010] EWCA Civ 1216, Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin),* and *El Karout v Nursing and Midwifery Council [2019] EWHC 28 (Admin).* He submitted that it is contrary to the Rules and unfair to admit this evidence for the following reasons:

- Reliance has been placed on some purported failing on behalf of your representatives (the RCN) to 'flag issues' for the NMC to consider. This is a submission without basis in fact or law.
- The Case Management Form was served on the NMC on 27 February 2019. This indicated which charges would be admitted and denied. At no stage has it been suggested by the NMC that the information provided was insufficient, nor has any request been made for further particulars of the issue in the case.
- By a document dated 3rd June 2019, the RCN indicated which elements of the witness statements and which exhibits they considered ought to be redacted from the proposed bundles, with short reasons in justification advanced in

respect of the requests made. In respect of SJ/5, it was said that the entire exhibit ought to be removed from the bundle since, '*The author is not a witness or able to speak to it'*. The document was then removed from the panel's bundle without further discussion.

- The document sought to be admitted contains an investigation report from Dr 7, concerning the events surrounding the allegations of 29th July 2017. It contains disputed assertions of fact, purported evidence from other persons, and conclusions. Whilst Dr 7 is a known person, in touch with the NMC, at no stage have they sought to take a witness statement from him, nor indicated he was being considered as a witness. Instead, the witness who purports to exhibit the document (Mr 5) professes no first-hand knowledge of the truth or otherwise of the assertions made within it.
- It is unfair to admit the document as there is no mechanism by which you can test the accuracy of those assertions, nor otherwise challenge the evidence.
- That unfairness is compounded by the document's "double hearsay" contents: i.e. factual assertions said to have been made by a person other than the author, themselves contained in a document that no witness is capable of speaking to. If true and accurate, such assertions (which are said to have emanated from the named individuals Patient A and Mr 6) go to the core of the issue of the reliability of the CCTV. Neither of those named in the document have signed it to confirm its accuracy; no statements are available from them; and nor is there any indication they have ever been made aware of the assertions that are attributed to them.
- There is a real procedural unfairness in the timing of this application. As Spencer J set out in El Karout, [paragraphs 137 to 139] the proper time for any such central issues of law to be indicated and determined is either: in advance of the substantive hearing before another panellist at a preliminary meeting; or at least at the very outset, before the charges are read and the particular panel seized with the responsibility of determining the facts. The approach of the NMC means that the panel who must determine the proof or otherwise of serious charges must pause their determination to grapple with significant legal issues and

consider the admissibility of evidence that all had seemingly previously agreed it was unfair to adduce.

- The evidence of SJ/5 is the sole evidence capable of bearing on the issue of the accuracy and reliability of the portion of CCTV considered. That must be the decisive evidence on the determination of the outstanding charges in relation to the 29th July 2019. Both Dr 1 and Mr 2 have and will give evidence as to what they saw on the footage provided to them, but cannot evidence how that footage came to be produced, and whether it is in fact the material portion.

Mr Jamieson submitted that SJ/5 is of decisive importance in the determination of serious charges before the Committee, including dishonesty. There are no safeguards as to its reliability; and indeed there are real issues as to its unreliability. Fundamentally, should the document be admitted there is no possible way for you to materially challenge the contents of the assertions made within it, compounding the level of unfairness already present within this hearing with the lack of the CCTV. The authorities are clear and consistent that to admit evidence in these circumstances would be grossly unfair, and ought not to be permitted.

The panel accepted the advice of the legal assessor which included reference to Rule 31 and the cases of *Ogbonna v Nursing and Midwifery Council [2010] EWCA Civ 1216, Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin),* and *El Karout v Nursing and Midwifery Council [2019] EWHC 28 (Admin).*

Panel decision

The panel had regard to the written and oral submissions of Ms Stokes and Mr Jamieson, and exhibit SJ/5.

The panel took into account that the NMC had not sought to obtain witness statements from the relevant individuals. The panel considered the reliability of SJ/5 and considered

that the evidence was inherently weak. The panel noted that there were references to different time periods covered by the footage. Further Dr 7 viewed the CCTV footage, as did Dr 1, however this does not take the issue of whether the footage was of the relevant time and place any further. The panel concluded that it had concerns with the reliability of the evidence, and that it could not be considered demonstrably reliable.

The panel considered the fairness of admitting SJ/5 at this stage in proceedings. The panel bore in mind that the burden is on the NMC to prove the facts of the case. The panel noted that the charges contain very serious allegations of dishonesty. The panel considered that the CCTV footage is relevant to this as the assertion of dishonesty is on the basis you were not seen going into Patient A's cell to administer the gabapentin on the footage.

The panel considered that the significance of this footage should have been taken into account at the investigation stage and all proper efforts to confirm its reliability should have been taken then. The panel considered that you are entitled to test and challenge the evidence against you, and it is the duty of the NMC to ensure that the evidence is strong enough to stand up to that examination.

The panel considered that neither Dr 7 nor Mr 6 have been given witnesses statements or been called to give evidence. The panel agreed with Mr Jamieson's submission that the evidence contained therein was "double hearsay". It further considered that if the evidence were admitted you, and indeed the panel, would have no means to test the evidence and deal with the inconsistencies.

The panel accepted that an agreement had been reached between the NMC and your legal representatives that SJ/5 was disputed, it should be removed from the bundle. The panel balanced fairness to the NMC, including the need to protect the public and the public interest with fairness to you.

The panel concluded that it would still be unfair to you to admit the evidence at this stage of the proceedings as Dr 7 is not a witness and there is no mechanism available to test the assertions contained in the investigation report. As there are no safeguards as to the reliability of SJ/5 and real issues as to its unreliability that cannot be properly challenged by cross-examination, it would be unfair to admit the document in evidence under Rule 31 (1) of the Rules.

Accordingly, in these circumstances the panel refused the application.

Application to adjourn

Ms Stokes applied for the case to be adjourned in order to allow the NMC to obtain further evidence from Mr 6 and Dr 7. Ms Stokes referred the panel to the case of *The Professional Standards Authority v (1) The Nursing and Midwifery Council (2) Jozi [2015] EWHC 764 (Admin)* and submitted that the panel have a responsibility to ensure that the full regulatory concern is dealt with. She submitted that the overriding issue is one of fairness and this includes fairness to the NMC.

Ms Stokes submitted that if the panel did not wish to adjourn the entire hearing until a later date immediately, the panel could hear evidence from Mr 4, whose evidence is not related to the CCTV footage, to expeditiously use the time available.

Mr Jamieson opposed the application. He submitted that there is a public interest in the expeditious disposal of the hearing. He submitted that if the facts stage could be concluded this week that would be a significant landmark for you. Mr Jamieson submitted that failures of the NMC to obtain evidence should not permit an adjournment of these proceedings to be allowed.

Panel decision

The panel decided to adjourn the hearing to allow the NMC time to make further enquires. In the circumstances, the panel decided to utilise the time available and hear the evidence of Mr 4. The hearing would then adjourn until the morning of day 5 of the hearing, at which time the panel would require an update from the NMC as to the progress it has made in obtaining the new evidence, and its proposed course. In reaching this decision the panel balanced fairness to the NMC, the public interest in ensuring that the issues are properly tested, and your right to a fair hearing.

On day 5 of the hearing Ms Stokes informed the panel that the NMC had contacted Dr 7 and he has confirmed that he is available to give a witness statement in the week commencing 24 June 2019. Ms Stokes told the panel that the NMC are awaiting contact details for Mr 6 and that these are forthcoming.

The panel decided to impose the following case conduct directions under Rule 32(3) of the Nursing and Midwifery Order 2001:

1. The resuming hearing shall be listed on 4 November 2019 for 5 days.
2. The NMC shall serve on the registrant any new evidence on which they will seek to rely at the resuming substantive hearing by 1 August 2019.
3. There shall be a case management directions hearing on 7 October 2019 commencing at 9.30am.
4. If there is any legal argument regarding admissibility of evidence, skeleton arguments shall be exchanged by both parties by 30 September 2019.
5. If any skeleton arguments are required, these are to be provided to the panel in advance of the case management hearing on 7 October 2019.

Resuming hearing 4 November 2019

The charges arose whilst you were employed as a Registered Nurse by Mitie Care and Custody Health, British Transport Police. You worked at the Central London Police Station, Whitfield Street.

The regulatory concerns with your practice relate to the failure to administer medication to a patient when it was due, the failure to follow procedure for authorising the administration of medication to another patient, the falsification of documents and associated dishonesty.

On 29 July 2017, it is alleged that whilst working at the Central London Police station, you did not give anti-epileptic medication to Patient A. It is also alleged that, after you failed to administer medication, you falsified documentation by recording that you had.

The CCTV covering the time period in question was reviewed by the inspector, who observed that no medication had been given based on the fact that the Patient A had not left her cell and no healthcare professional had attended her cell.

It is further alleged that you failed to obtain authorisation to administer controlled drugs to Patient B on 9 April 2017. It is further alleged your actions were dishonest as you knew you did not obtain authorisation and you knew it was wrong to give the misleading impression that you did.

Decision on the findings on facts and reasons

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

Ms Stokes invited the panel to find charges 1, 3 and 5 proved. She referred the panel to your apparent admissions, in the presence of your legal representatives during the meeting on 15 June 2017 as recorded in the notes of the meeting. She referred the panel to the evidence of Mr 2 who explained that controlled drugs could not be given without appropriate authorisation, which he described as a second checking or peer support process.

Ms Stokes submitted that Mr 3 confirmed that he did not authorise you to administer the controlled drugs to Patient B on 9 April. Ms Stokes submitted that by writing in Patient B's MAR charts you sought to give the misleading impression that you had obtained authorisation. Ms Stokes submitted that you created this misleading impression deliberately.

Mr Jamieson submitted that the burden was on the NMC to show that you failed to meet an obligation to obtain authorisation before administering the controlled drugs to Patient B, but that they had not provided evidence that any such obligation existed. He reminded the panel that it did not have before it any policy confirming the duty.

Mr Jamieson submitted that Mr 2 was confused and uncertain in his evidence. Mr Jamieson said that you accept that your actions were not best practice and that you did not phone Mr 3 before administering the controlled drugs. He said that you believed authorisation was given to another nurse which was then transferred to you in handover. Mr Jamieson submitted that there was no benefit to you to be dishonest by creating a misleading impression, and that you accurately recorded a drug you had administered. He invited the panel to find charges 1, 3 and 5 not proved.

The panel heard and 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 is more likely than not that the incidents occurred as alleged.

The panel heard oral evidence from three witnesses called on behalf of the NMC:

Dr 1 – *Lead Clinician for Mitie Group Plc*;
Mr 2 – *Contract Manager for the British Transport Police*;
Mr 3 – *Senior Health Care Professional for Mitie*;

The panel found Dr 1 to be a credible and reliable witness. She appeared balanced in her evidence and answered questions clearly. The panel found that Dr 1 conceded when she was unable to answer a question; however, it noted that Dr 1 did become somewhat defensive when the validity of the CCTV was in question.

The panel found Mr 2 to be credible and reliable. He presented well and appeared balanced in his evidence. The panel noted that he did admit that he got confused during defence questioning. The panel considered that Mr 2 gave his evidence within the limits of his knowledge and understanding.

The panel found Mr 3 to be a credible and reliable witness. He was clear in his evidence and did not try to embellish matters or give opinion. He remained factual and did not try to make matters worse for you. Mr 3 was clear that it was the duty of staff to get a second checker as means of authority to administer he was not in a position of authority as a prescriber.

The panel did identify any personal hostility against you by any of the three witness.

At outset of this hearing you admitted the following charges;

2. On 9 April 2017, signed a Diazepam Medication Administration Record indicating that you had obtained authorisation to administer the drug **[proved by way of admission]**

4. On 9 April 2017, signed a Dihydrocodeine Medication Administration Record indicating that you had obtained authorisation to administer the drug **[proved by way of admission]**

7. On 29 July 2017, signed Patient A's notes indicating that you had administered gabapentin at 14.30 **[proved by way of admission]**

At the outset of the resumed hearing commencing on 4 November 2018 (day 6 of the hearing) you admitted the following charges:

6. On 29 July 2017, at around 14.30 failed to administer gabapentin to Patient A **[proved by way of admission]**

8. And your action specified in charge 7 was dishonest in that:
   a) You knew that you had not administered gabapentin at 14.30 **[proved by way of admission]**
   b) You knew that it was wrong to give the misleading impression that you had administered the drug at 14.30 **[proved by way of admission]**

These were therefore announced as proved.

The panel then went on to consider the remaining charges.

The panel considered each charge and made the following findings:

Charge 1 and Charge 3

1. On 9 April 2017, failed to obtain authorisation to administer diazepam to Patient B before administering such

3. On 9 April 2017, failed to obtain authorisation to administer dihydrocodeine to Patient B before administering such

These charges are found proved.

In reaching this decision, the panel took into account all the evidence before it.

The panel noted that you accepted that you administered the dihydrocodeine and diazepam (the Controlled Drugs) to Patient B on 9 April 2017.

The panel noted that for you to have failed to obtain authorisation to administer the controlled drugs, you had to be under a duty to obtain authorisation.

The panel heard evidence about the Patient Group Directive (PGD) which allows the healthcare professional to administer or supply medicines to pre-defined groups of patients, without a prescription. Although the plan was in day to day use it had not been signed off by the British Transport Police. The panel did not have sight of the PGD but concluded that there was system in regular use that governed the administration of medication and that under this system you had a duty to obtain authorisation prior to administering certain medications.

In reaching this conclusion, the panel had regard to Mr 2's evidence to the panel. In answer to questions from Ms Stokes regarding the procedure on administering drugs if a medical professional has not been granted authorisation, Mr 3 stated "They would

have to get authorisation. There is no getting around giving out controlled drugs without authorisation".

The panel considered whether Mr 4 could have provided appropriate authorisation to you in his handover. It had regard to your comments in the Notes of Meeting on 15 June 2017. You stated that Mr 4 tried to give a handover at the custody desk and you asked him to go into a meeting room to do it. Mr 4 said he spoke to Mr 3 and he was told to give the Controlled Drugs, and this was what was handed over to you.

The panel considered the evidence of Mr 2. He confirmed that authorisation could not be continuing or an "ongoing process". He confirmed that "Each time, that medication for that individual has to be authorised".

The panel considered that Mr 2 also explained that the authorisation process was in place as you "have to do an assessment of that individual, because the individual could present differently after the next dose of drugs is required. It is about safeguarding the staff, the patient, and the company."

The panel had regard to the meeting notes where you state: "I regret not following procedure, I should have phoned and logged". The panel noted that you were also aware of why the authorisation procedure was in place, namely "safe practice, help patient, second opinion".

The panel concluded that the authorisation process in this context was akin to a second checker process in which two people were required to consult with one another in agreeing a course of action to derive authority. Mr 2 when questioned by the panel confirmed that this was a "safety mechanism for the patient, for the nurse, health care professional and the company".

The panel had regard to Mr 3's evidence that you did not obtain authorisation from him for the administration of the medications listed in charges 1 and 3. It also noted that you accept this as the position.

In these circumstances the panel decided that you were under a duty to obtain appropriate authorisation yourself before administering the controlled drugs, and by not doing so, you failed to obtain that appropriate authorisation.

Accordingly, the panel finds charges 1 and 3 proved.

Charge 5

And your actions specified in charges 2 and 4 were dishonest in that:
a) You knew that you had not obtained authorisation
b) You knew that it was wrong to give the misleading impression that you had obtained authorisation to administer the drugs

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it.

The panel had regard to the 15 June 2017 meeting notes where you state, in the presence of your legal representative: "I regret not following procedure, I should have phoned and logged". You also confirmed that you understood the reasons for getting authorisation, and that you knew of the process, and that you obtained a 97% score on the training assessment for PGDs.

The panel accepted that the evidence before it is that you did not obtain that authorisation. Mr 3 told the panel that you did not telephone him and ask him for authorisation.

The panel had regard to the Medication Administration Record (MAR chart) for Patient B in relation to the Controlled Drugs. It noted that you had written “authorised by [Mr 3]” next to your entries.

In the meeting notes dated 15 June 2017 you suggested that you had obtained authority via Mr 4 through the handover process. However, the panel did not accept that it was possible to obtain authority in this manner. The panel decided that it was clear from the meeting notes and from the evidence of Mr 2 that appropriate authorisation was required at the point of administering the drug and could not be implied from a previous authorisation.

The panel considered that you were fully aware that there was an authorisation process in regular use, and therefore concluded on the balance of probabilities that you knew you had not obtained the proper authorisation for the administration of the controlled drugs to Patient B on 9 April 2017. The panel found that by writing “authorised by [Mr 3]” next to your entries on Patient B’s MAR charts you knew that you would be giving a misleading impression. The panel found that based on the set out test in *Ivey v Genting Casinos Ltd [2017] UKSC 67*, your actions were objectively and subjectively dishonest.

For these reasons the panel found charge 5a) and 5b) proved.

Submission on misconduct and impairment

Having announced its finding on all the facts, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

Ms Stokes provided the panel with detailed written submissions. In summary:

In her submissions Ms Stokes invited the panel to take the view that your actions amounted to a breach of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)* (the Code). She then directed the panel to following specific paragraphs: 1.2, 1.2, 1.4, 3.1, 3.4, 8.2, 8.3, 8.5, 8.6, 10.1, 10.3, 10.4, 18.1, 20.1, 20.2, and 20.5 and identified where, in the NMC's view, your actions amounted to misconduct.

Ms Stokes referred the panel to the case of *Roylance v GMC (No. 2) [2000] 1 AC 311* which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

Ms Stokes submitted that a key point to which she wanted draw the attention of the panel is that Patient A and Patient B, by being detained in custody, were both vulnerable. She submitted that this makes the failings more serious.

Ms Stokes submitted that your actions as proven fall far short of what would be expected of a registered nurse. Colleagues would expect that they could rely upon their other colleagues to deliver safe and effective care and maintain honest and accurate records. The public expect that the profession would properly care for friends, relatives and members of the public. Not only is it unacceptable to fail to provide the requisite standard of care, it is further compounded by making dishonest records in an attempt to conceal one's mistakes or shortcuts. Ms Stokes submitted that the false entries in

relation to Patient A and the misleading entries in relation to Patient B show a significant departure in the standards expected of a registrant in your position.

She then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Ms Stokes referred the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), Nandi v GMC [2004] EWHC 2317 (Admin), Calhaem v GMC [2007] EWHC 2006 (Admin).*

Ms Stokes informed the panel that in October 2010, a previous Panel of the NMC Conduct and Competence Committee found your fitness to practise impaired and made you the subject of a Conditions of Practice Order for twelve months. This was in relation to two matters. Firstly, a serious drug error from June 2005 whereby you administered 50 units of insulin to a patient in one dose rather than through saline over a 24 hours period. The second matter arose from you having caused discomfort to a patient whilst inserting a cannula which was subsequently inserted by a doctor. Your actions of inserting the cannula went against the policy in place at the time which stated cannulas should only be inserted by a doctor. On 11th March 2013 the panel allowed the order to expire as your fitness to practise was no longer impaired.

Ms Stokes submitted that the risk of harm has been present in the past in the light of the previous findings, and is a risk for the future in light of the current case. She invited the panel to note that the previous Fitness to Practise Panel finding also relates to failures to follow the appropriate policy in place.

Ms Stokes submitted that the four limbs of the Grant test were engaged in this case.

Ms Stokes submitted you have demonstrated dishonesty in relation to both Patient A and Patient B, as found by proved by the panel. She submitted that the findings relate to

a lack of candour and dishonesty, and exhibit an attitudinal problem. She submitted that a finding of impairment in this case is necessary both to protect the public and is in the public interest in upholding the standards of the profession.

Mr Jamieson provided the panel with a bundle of documents which included a reflective piece, testimonials from your previous nursing employment, and training certificates.

You gave evidence under oath at this stage. You told the panel of your career history, and explained that you have worked in healthcare for 25 years. You told the panel of [PRIVATE] and issues at work at the time of the incident. You also explained your reflective piece and why you acted the way you did. You apologised to Patient A and Patient B, and explained what you would do differently in the future.

Mr Jamieson made it clear that you accept that the charges admitted and found proved amounted to serious misconduct, and also that you accept that you are currently impaired on both public protection and public interest grounds. He felt however it would be important for the panel to consider closely some background issues which is why you had chosen to give evidence at this second stage of the proceedings.

Mr Jamieson submitted that, in mitigation of your actions, [PRIVATE]. He submitted that [PRIVATE] are relevant when considering whether dishonesty can be remediated. Mr Jamison told the panel that the dishonesty occurring at this time is the only time dishonesty has been raised regarding your practice.

Mr Jamieson accepted that your admissions to charges 6 and 8 did not happen as soon as they should have done. Mr Jamieson referred the panel to your reflective piece and submitted that this is a genuine reflection and this shows that you have considered the impact of your dishonesty as you have applied it to your current volunteering roles.

Mr Jamieson submitted that you have been candid regarding what has been going on in your life, and you have sought worthwhile volunteer work when you have not been able to secure employment under your interim conditions of practice order.

The panel has accepted the advice of the legal assessor which included reference to a number of judgments which are relevant, these included: *Roylance v General Medical Council (No 2) [2000] 1 A.C. 311* and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).*

The panel adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct

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

The panel, in reaching its decision, 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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

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, and

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk, and

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

The panel acknowledged that breaches of the Code do not automatically result in a finding of misconduct. The panel also noted that you accept that your failings amount to misconduct.

The panel were of the opinion that charges 6, 7, and 8 were particularly serious. They relate to dishonesty in a professional capacity, direct clinical care, and the breach of the duty of candour. The panel determined that you constructed a fiction regarding a patient, which represented the patient as a liar, further exploiting their vulnerability and potentially causing a risk of harm from not receiving prescribed medication.

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. The charges taken as a whole are so serious as to amount to misconduct.

Decision on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the 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 Grant were engaged.

The panel accepted that you have demonstrated some remorse for your failings. When giving evidence to the panel you apologised to Patient A and Patient B, and said that you felt ashamed of how you acted. The panel were concerned that the admissions to charges 6 and 8 came at a very late stage in the proceedings. The panel noted that you did not admit these charges until the start of the resuming hearing on 4 November 2019. The panel concluded that you only admitted these charges after viewing CCTV evidence which confirmed that you did not attend Patient B. In these circumstances, the panel was unable to give significant weight to the remorse that you had demonstrated.

In its consideration of whether you have remedied your practice the panel noted that you are volunteering for the RNLI and Women at the Well. The panel considered your volunteer work was commendable and demonstrated compassion and a genuine willingness and commitment to helping others. The panel also had regard to the training you have undertaken which was relevant to the charges found proved. You presented certificates in the following:

- Law, Ethics, Professional Accountability, Record Keeping and documentation workshop 20 May 2019
- Adult Critical Care Workshop 30 April 2019
- IV therapy workshop 6 April 2019
- Control and Administration of Medicines Level 3 6 February 2019
- Documentation and record keeping Level 2 8 February 2019

However, the panel concluded that your remediation regarding your dishonesty remained lacking. The panel noted that you attended the Law, Ethics, Professional Accountability, Record Keeping and documentation workshop on 20 May 2019 which related to honesty in the profession. However, at the start of the hearing in June 2019, you did not admit to the full extent of your dishonesty. The panel were concerned that you had not learnt enough from this course to admit your dishonesty as you did not admit your dishonesty until the 6th day of this hearing.

In respect of your insight, the panel had regard to your reflective piece. The panel noted that you made some admissions at the outset of the hearing. You apologised to the patients, albeit only once you gave your evidence at the second stage of these proceedings. You did not seek to make excuses for your failings. You accepted that you were thinking of yourself and not of your patients. The panel noted that when questioned about what you would do differently in future you explained that you would inform someone and take yourself out of the situation. However, the panel considered that you had not gained a full appreciation of how your actions impacted negatively on the reputation of the nursing profession.

[PRIVATE].

The panel took into account that you accept that you are currently impaired. You told the panel that you would need to undertake a return to practice programme before you felt able to return to nursing work.

The panel was of the view that your failings placed vulnerable patients at a risk of harm. In relation to Patient A and the failure to give an anti-epileptic, this deliberate omission had the potential to cause serious harm to the patient given the purpose of such medication. Further, by recording this as done, this would prevent other clinicians from accurately assessing the medication doses that had been given. In relation to Patient B the failure to adhere to the second checker process could put the patient at risk as one of the main purposes of this was to ensure the drug being administered was appropriate and safe. Although the panel recognised that you are taking commendable steps to demonstrate your contrition, it concluded that due, to your late admission in this hearing and the incomplete appreciation of the effect of your dishonesty on the reputation on the profession, that there remains a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC 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, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. Dishonesty is particularly serious as this greatly undermines public trust in the profession. The panel determined that, in this case, a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Submissions and determination on sanction

You gave evidence at this stage. You told the panel that you knew that the misconduct of nurses can compromise confidence in the nursing profession, and you risk jeopardising the trust the public have in nurses when dealing with vulnerable patients at a vulnerable time in their lives. You said that it is important for the public to trust nurses so they can feel confident that their lives and the lives of their loved ones are safe. You told the panel that you recognise that the conduct of an individual nurse can also have an impact on the NMC as they have to maintain professional standards.

Ms Stokes provided detailed written submissions. In her submissions, she invited the panel to impose a striking-off order. Ms Stokes outlined what the NMC considered to be the aggravating and mitigating features of this case, and submitted that, because of the seriousness of the facts underlying your misconduct, the only sanction that would appropriately satisfy the public interest and protect the public would be to remove your name from the register. Ms Stokes submitted that the reputation of the profession is more important than the fortunes of any individual nurse.

Mr Jamieson provided detailed written submissions. In his submissions, he recognised that this was a finely balanced case and agreed that a period of removal from the register is required to reflect the seriousness of the departure from the standards: to safeguard the public interest; and to protect against future risk.

Mr Jamieson reminded the panel that there is a public interest in returning nurses who are capable to safe and effective practise. He submitted that you should be afforded the chance to convince a review panel that you are capable of returning to safe practice. He invited the panel to consider the specific context to your actions when determining the magnitude of the risk. He submitted that you have admitted what you have done was wrong and have not sought to minimise this.

Mr Jamieson submitted that [PRIVATE] and you are not seeking to make excuses. Mr Jamieson submitted that the panel have heard the pressures you were under, and the panel should consider the impact this had on you [PRIVATE].

The panel considered this case and decided to make a striking-off order. It directs the registrar to strike your name off the register. The effect of this order is that the NMC register will show that your name has been struck off the register.

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case. The panel accepted the advice of the legal assessor. The panel 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 had regard to the aggravating and mitigating features in this case.

The panel considered the aggravating features to be:

- The second incident occurred shortly after you had received a final written warning
- You have a previous regulatory finding, however it is noted that the concerns were different from those before this panel
- Your conduct put Patient A at a risk of harm
- You exploited the vulnerability of Patient A by constructing a fictional account on the premise that you would be believed over Patient A
- There has been no clear explanation as to why you behaved as you did regarding Patient A
- You made very late admissions to the charges relating to Patient A. The late admissions came only at the beginning of the resumed hearing on 4 November, after viewing the CCTV. You did not admit charges 6 and 8 at the outset of the

hearing in June 2019, despite having attended a course on professional ethics in May 2019.

The panel considered the mitigating features to be:

- [PRIVATE]
- No evidence of repetition of the regulatory concerns
- The previous regulatory finding in 2010 was not related to your honesty
- You have demonstrated, through your voluntary work, a commitment to helping others

The panel considered the seriousness of your dishonesty with reference to the factors set out in the Sanctions Guidance, and noted the following features were present in this case.

More serious

- deliberately breaching the professional duty of candour to cover up when things have gone wrong, especially if it could cause harm to patients
- vulnerable victims
- direct risk to patients

Less serious

- opportunistic or spontaneous conduct
- no direct personal gain
- incidents in private life of nurse or midwife

The panel bore in mind that you had attended this hearing throughout and expressed remorse and accepted that you have acted in a dishonest way, and that the Sanctions Guidance states that this *"may be able to reduce the risk that they will be removed from the register".*

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.

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 your 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel 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 your registration would not adequately address the seriousness of this case, maintain public confidence in the profession and the NMC as its regulator, or adequately protect the public.

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

- Whether the seriousness of the case require temporary removal from the register?
- will a period of suspension be sufficient to protect patients and the public interest?

This sanction may 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 there is some evidence of attitudinal problems. The panel remained concerned that your admissions to charges 6 and 8 came at a very late stage in the proceedings, and that you did not admit to the full extent of your dishonesty, until after viewing the CCTV. Furthermore, you were not able to give a clear explanation for the motivation for acting in the way you did. The panel was of the view that whilst there may not have been malicious intent, it was not clear what had led to you being dishonest such that the panel could not exclude the risk repetition. The panel considered the seriousness of your dishonesty, particularly in relation to Patient A, where you constructed a fiction regarding a patient, which represented the patient as a liar, further exploiting their vulnerability and potentially causing a risk of harm from not receiving prescribed medication.

The panel noted that you have demonstrated developing insight. However, the panel also bore in mind that the charges contain two incidents of dishonesty. The panel considered that late admission of the charges involving Patient A also evidences a predisposition not to be upfront and honest. In these circumstances, the panel could not be satisfied that there is no significant risk of your repeating the behaviour if faced with [PRIVATE] challenging situations or circumstances.

The panel has taken into account the mitigation advanced by Mr Jamieson on your behalf. The panel considered that you have engaged in worthwhile pursuits such as your volunteering, and you have attempted to remediate your misconduct. However, given the seriousness of the facts of this case the panel was not satisfied that the steps you have taken to remediate your conduct were sufficient for it to conclude that a suspension order was proportionate.

The panel took into account the eloquent submissions made both in writing and orally by your counsel Mr Jamieson, but concluded, taking all of the factors into account, that a suspension order would not be an appropriate or proportionate sanction.

In looking at a striking-off order, the panel took noted of the following from the Sanction Guidance:

- 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?

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel decided that the serious breaches of the fundamental tenets of the profession evidenced by your actions and omissions is fundamentally incompatible with your remaining on the register.

Taking into account all the evidence before it during this case, the panel determined 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 your dishonest 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 a striking-off order would be sufficient in this case.

The panel was of the view that the findings in this case were particularly serious such that to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. 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

The panel considered the submissions made by Ms Stokes that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest. Mr Jamieson made no submissions.

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 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. To do otherwise 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 you are sent the decision of this hearing in writing.

That concludes this determination.