Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
16 – 24 September 2019

Nursing and Midwifery Council, 114-116 George Street, Edinburgh, EH2 4LH

Name of registrant:	Matthew McCardle
NMC PIN:	99J0119S
Part(s) of the register:	Nursing, Sub part 1 RNA, Registered Nurse-Adult (30 September 2002)
Area of Registered Address:	Scotland
Type of Case:	Misconduct
Panel Members:	Tim Cole (Chair, lay member) Angela O'Brien (Registrant member) Jane McLeod (Lay member)
Legal Assessor:	Maria Clarke
Panel Secretary:	Tara Hoole
Mr McCardle:	Not present or represented in his absence
Nursing and Midwifery Council:	Represented by Charles Drinnan, NMC Case Presenter
Facts proved:	1.1, 1.4, 2.1, 2.3 and 6 in its entirety
Facts proved by admission:	2.4, 2.6, 2.7, 3.3, 3.4, 3.5 and 5
Facts not proved:	1.2, 1.3, 2.2, 2.5, 3.1, 3.2 and 4
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim Order:	Interim suspension order (18 months)

Details of charge:

That you, a registered nurse, whilst working on the Medical Assessment Unit ("MAU"), at Borders General Hospital:

1) On 14 October 2017 whilst acting as a second checker for the administration of 240mg of Furosemide to Patient A:

   1.1) Did not check that the prescription for Patient A was complete; **found proved**

   1.2) Did not check that the medication for Patient A should not have been administered; **found not proved**

   1.3) Did not check that the Furosemide should have been a slow infusion over a period of 24 hours; **found not proved**

   1.4) Allowed the Furosemide to be administered over a one hour period; **found proved**

2) On 20 October 2017 whilst preparing and/or administering Clarithromycin for Patient B:

   2.1) Incorrectly diluted the Clarithromycin with 10mls of saline solution instead of 10mls of water; **found proved**

   2.2) Administered Clarithromycin at 6p.m. to Patient B, without a second checker; **found not proved**

   2.3) Ignored Patient B's complaint that their skin was sore; **found proved**

2.4) Did not stop the infusion of the Clarithromycin; **found proved by admission**

2.5) Administered the Clarithromycin into Patient B's tissue instead of their vein; **found not proved**

2.6) Incorrectly diluted the Clarithromycin in a 50ml bag of saline instead of a 250ml bag of saline; **found proved by admission**

2.7) Programmed the pump for administration for 15 minutes instead of 30 minutes as required; **found proved by admission**

3) On 22 October 2017 whilst administering a Parvolex infusion to Patient C:

3.1) Administered the drug independently without a second checker; **found not proved**

3.2) Pierced an incorrect entry point on the infusion bag of Parvolex; **found not proved**

3.3) After noticing a leak in the Parvolex infusion bag you did not replace it with a suitable alternative; **found proved by admission**

3.4) Used mepore tape to attempt to stop the leak on the Parvolex infusion bag; **found proved by admission**

3.5) Did not complete a Datix for the incidents which occurred in charges 3.1, 3.2, 3.3 & 3.4 above; **found proved by admission**

4) Between August and October 2017 responded rudely to A Foundation doctor in regards to prescribing medication; **found not proved**

5) On 23 June 2017 communicated unprofessionally and/or abruptly with Patient D's wife, Person 1; **found proved by admission**

6) On 20 October 2017 intimidated Colleague 1 in that you:

6.1) Used words to the effect of "You're going to write this really? Really?" **found proved**

6.2) Followed Colleague 1 around the unit and used words to the effect of "We need to talk." **found proved**

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

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Mr McCardle was not in attendance and that written notice of this hearing had been sent to Mr McCardle's registered address by recorded delivery and by first class post on 13 August 2019. Notice of this hearing was delivered to Mr McCardle's registered address on 14 August 2019 and signed for under the printed name 'McCardle'.

The panel took into account that the notice letter provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mr McCardle's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Mr Drinnan submitted the NMC had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr McCardle has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34. It noted that the rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision on proceeding in the absence of the Registrant

The panel next considered whether it should proceed in the absence of Mr McCardle. The panel had regard to Rule 21 (2) which states:

> (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—
>
> (a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;
>
> (b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or
>
> (c) may adjourn the hearing and issue directions.

Mr Drinnan invited the panel to continue in the absence of Mr McCardle on the basis that he had voluntarily absented himself. Mr Drinnan took the panel through recent email correspondence from Mr McCardle. Mr Drinnan submitted Mr McCardle had been clear and consistent in his position that he would not be in attendance at this hearing and that he would not be engaging with the process beyond the documentation he had provided. As such, Mr Drinnan submitted, it was clear that Mr McCardle had voluntarily absented himself and there was no reason to believe that an adjournment would secure his attendance on some future occasion.

Mr Drinnan reminded the panel of the public interest in concluding these matters expeditiously. Further, Mr Drinnan submitted that there were a large number of witnesses warned to give evidence in these proceedings who would be inconvenienced should the hearing not proceed.

The panel accepted the advice of the legal assessor.

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

The panel noted the correspondence from Mr McCardle. In an email dated 31 July 2019 to his NMC Case Officer, he stated '*I am writing finally to reiterate the reasons previously stated in my submissions that I will not attend any subsequent hearing, either in person or by video link*.' He goes on to state: '*In summary It [sic] is with the greatest respect that I decline attendance or video link for hearing…*'. Further in his email of 10 September 2019 he stated *'I have consistently stated my position. It has not changed*.'

The panel has decided to proceed in the absence of Mr McCardle. In reaching this decision, the panel considered the submissions of the case presenter, the correspondence from Mr McCardle and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R. v Jones (Anthony William)*, (No.2) [2002] UKHL 5 and the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162.

It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- no application for an adjournment has been made by Mr McCardle;
- Mr McCardle has been clear and consistent in his position that he does not wish to attend this hearing and his reasons for this;
- there is no reason to suppose that adjourning would secure his attendance at some future date;
- three witnesses have attended today to give live evidence, five others are due to attend;
- not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- the charges relate to events that occurred in 2017;

- further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- there is a strong public interest in the expeditious disposal of the case;
- it may also be in Mr McCardle's own interest for this case to be concluded at the earliest opportunity.

There is some disadvantage to Mr McCardle in proceeding in his absence. However, in the panel's judgment, this can be mitigated. Mr McCardle has provided a response to the charges. Although he will not be able to directly challenge the evidence relied upon by the NMC and will not be able to give live evidence on his own behalf, his views can be put to the witnesses for comment. Further the panel can make allowance for the fact that the NMC's evidence will not be directly tested by Mr McCardle's cross examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr McCardle's decisions to absent himself from the hearing, waive his rights to attend and/or be represented and to not provide oral evidence or make submissions on his own behalf.

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

Decision and reasons on application under Rule 19

At the outset of the hearing the panel, of its own volition, raised that some of Mr McCardle's written representations contained reference to his health which may require the hearing to be heard in private under Rule 19 of the Rules. The panel invited Mr Drinnan to comment.

Mr Drinnan indicated that he supported any reference to Mr McCardle's health being heard in private. However, he opposed the entire hearing being heard in private. He told the panel that he would not be making reference to Mr McCardle's health when presenting his case and proposed it would be sufficient to go into private if and when any reference to Mr McCardle's health was made. Mr Drinnan reminded the panel it was in the public interest that hearings be heard in public.

The legal assessor reminded the panel that while Rule 19 (1) provides, as a starting point, that hearings shall be conducted in public, Rule 19 (3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to hold any parts of the hearing where there was reference to Mr McCardle's health in private. The panel determined to rule on whether or not to go into private session as and when such issues are raised and was satisfied the majority of the hearing could be heard in public.

Background

At the outset of the hearing Mr Drinnan outlined the background of Mr McCardle's case and provided some context to the allegations.

The NMC received a referral in relation to Mr McCardle's conduct and nursing practice on 19 January 2018.

The charges arose whilst Mr McCardle was employed as a staff nurse by NHS Borders Health Board (NHS Borders) on the medical assessment unit (MAU) at the Borders General Hospital (the Hospital). The MAU takes referrals and assesses patients to determine whether they require to be admitted to the Hospital, follow up by another service or can be discharged. Mr McCardle had been employed in this role since March 2016.

It is alleged that Mr McCardle was involved in three incidents involving poor adherence to safe medication management and three further incidents involving attitudinal and behavioural concerns towards both colleagues and patients' relatives. These incidents took place in the period between June and October 2017.

On 14 October 2017 Mr McCardle was acting as a second checker for the IV administration of Furosemide to Patient A. It is alleged that Mr McCardle did not fulfil his role as a second checker and as such a medication error was made.

On 20 October 2017 Mr McCardle was involved in a further incident. Mr McCardle was responsible for the administration of Clarithromycin to Patient B. It is alleged that Mr McCardle incorrectly prepared and incorrectly administered this medication to Patient B. Further, when Patient B complained it is alleged Mr McCardle did not act appropriately.

At some point later in the shift on 20 October 2019 it is alleged that Mr McCardle approached Colleague 1 and acted in a manner which was intimidating.

On 22 October 2017 a further medication administration incident was reported. Mr McCardle was responsible for the administration of Parvolex to Patient C. It is alleged that Mr McCardle administered the Parvolex to Patient C without a second checker present, that he pierced the infusion bag incorrectly and did not act appropriately when

he noticed the infusion bag was leaking. Further Mr McCardle did not complete a datix for this incident.

On 23 June 2017 Mr McCardle was involved in an incident in which it is alleged he communicated unprofessionally to Patient D's wife, Person 1.

It is alleged there was a further incident, between August and October 2017, where Mr McCardle responded rudely to a doctor.

Witness Assessment

The panel heard oral evidence from eight witnesses called on behalf of the NMC. The panel first considered the overall credibility and reliability of all of the witnesses it had heard from.

Ms 1 – Staff Nurse in the MAU at the Hospital at time of the allegations. The panel considered Ms 1 to be a credible and reliable witness. In relation to the incident detailed at charge 4 the panel considered her evidence to be somewhat vague and limited in scope. However in the panel's view she was consistent and confident in her evidence overall. She admitted her own mistakes and did not attempt to shift blame.

Ms 2 – Staff Nurse in the MAU at the Hospital at time of the allegations. The panel considered Ms 2 to be a credible and reliable witness. She admitted her own failings and said when she did not know.

Ms 3 – Staff Nurse in the MAU at the Hospital at time of the allegations. The panel considered Ms 3 to be a credible and reliable witness. She gave her evidence in a straightforward manner. The panel noted she had clearly been distressed by the incident she witnessed detailed at charge 5.

Ms 4 – Senior Charge Nurse in the MAU at the Hospital at time of the allegations. The panel considered Ms 4 to be a credible and reliable witness who did her best to assist the panel. However, the panel considered her evidence to be of limited assistance and it was clear that she was torn between her role as a manager and the reality of the situation at the hospital.

Ms 5 – Senior Staff Nurse in the MAU at the Hospital at time of the allegations. The panel considered Ms 5 to be a credible witness but of limited reliability. The panel noted several inconsistencies in her oral evidence which was, on occasion, contradictory. The panel considered she did her best to assist it however, she was not a direct witness to any of the incidents.

Ms 6 – Ward Co-ordinator and Charge Nurse in the MAU at the Hospital at time of the allegations. The panel considered Ms 6 to be a credible and reliable witness. She did her best to assist the panel and said when she did not know. The panel noted that Ms 6 was not a direct witness to any of the incidents and considered her evidence to be of limited assistance.

Colleague 1 – Staff Nurse in the MAU at the Hospital at time of the allegations. The panel considered Colleague 1 to be a knowledgeable, credible and reliable witness. She had a detailed recollection of the events she witnessed and was confident in saying when she did not know. The panel considered Colleague 1 to be a helpful witness who gave clear answers and did not try to embellish.

Person 1 – Patient D's wife. The panel considered Person 1 to be a credible and reliable witness. She gave a straightforward and candid account of an incident which occurred at what was clearly a distressing time for her. She attempted to see events from Mr McCardle's viewpoint and how her actions could have been interpreted. The panel found Person 1 to be an open and helpful witness.

Panel's findings on facts

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 Mr Drinnan, on behalf of the NMC, and the written responses from Mr McCardle.

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 was satisfied that it was more likely than not that the incidents occurred as alleged.

The panel has drawn no adverse inference from the non-attendance of Mr McCardle.

At the start of this hearing the panel had sight of Mr McCardle's written submission in which he admitted the following charges;

2) On 20 October 2017 whilst preparing and/or administering Clarithromycin for Patient B:

2.4) Did not stop the infusion of the Clarithromycin;

2.6) Incorrectly diluted the Clarithromycin in a 50ml bag of saline instead of a 250ml bag of saline;

2.7) Programmed the pump for administration for 15 minutes instead of 30 minutes as required;

3) On 22 October 2017 whilst administering a Parvolex infusion to Patient C:

3.3) After noticing a leak in the Parvolex infusion bag you did not replace it with a suitable alternative;

3.4) Used mepore tape to attempt to stop the leak on the Parvolex infusion bag;

3.5) Did not complete a Datix for the incidents which occurred in charges 3.1, 3.2, 3.3 & 3.4 above;

5) On 23 June 2017 communicated unprofessionally and/or abruptly with Patient D's wife, Person 1;

These were therefore announced as proved.

The panel then went on to consider the remaining charges and made the following findings:

Charge 1.1:

1) On 14 October 2017 whilst acting as a second checker for the administration of 240mg of Furosemide to Patient A:

1.1) Did not check that the prescription for Patient A was complete;

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's oral and written witness statement which she adopted as part of her evidence in chief, Mr McCardle's response to this charge and the continuous drug infusion chart for Furosemide for Patient A dated 14 October 2017.

Ms 1 told the panel that, on 14 October 2017, she was asked by a doctor to administer Furosemide to Patient A as a matter of urgency. Ms 1 asked Mr McCardle to assist her as second checker to administer the Furosemide to Patient A. Ms 1 explained to the panel that she had failed to realise that the continuous drug infusion chart she had been handed by the doctor was not fully completed and that Mr McCardle had not raised this either when he was assisting her with the preparation of the Furosemide.

Mr McCardle, in his written submissions, confirms this incident. He writes that he noted an inconsistency on the chart and that he raised this with Ms 1 whose only response was to '*frown and shrug'*.

When this was put to Ms 1 she was clear that Mr McCardle had not raised the issue with her. She explained what she would have done if he had raised any discrepancy.

The panel was of the view that if Mr McCardle had raised the issue of the prescription being incomplete he would have waited for the prescription to be completed before signing it as the second checker.

On balance the panel preferred Ms 1's evidence. The panel considered it to be more likely than not that Mr McCardle whilst acting as second checker for the administration of 240mg of Furosemide to Patient A that Mr McCardle did not check that the prescription for Patient A was complete.

The panel therefore found this charge proved.

Charge 1.2:

1.2) Did not check that the medication for Patient A should not have been administered;

This charge is found NOT proved.

The panel considered the wording of this charge to be confusing and unclear due in a significant part to the use of the double negative.

The panel considered, as it was unclear as to the meaning of this charge, it was impossible to determine where the proof supporting this charge lay. The panel reminded itself that the charges are for the NMC to prove and not for Mr McCardle to disprove.

On this basis, the panel found this charge not proved.

Charge 1.3:

1.3) Did not check that the Furosemide should have been a slow infusion over a period of 24 hours;

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 1's oral and written witness statements, the continuous drug infusion chart for Furosemide for Patient A dated 14 October 2017, the monograph for Furosemide, the patient notes for Patient A dated 14 October 2017 and the regular medication chart for Patient A for 14 October 2017.

The panel had nothing before it to confirm that the Furosemide should have been administered by a slow infusion over a period of 24 hours.

The panel had regard to the prescription of Furosemide on the continuous drug infusion chart which, as was established in respect of charge 1.1, was not complete. It considered that the fact that the Furosemide direction was given on this specific chart was not evidence in itself that the Furosemide should be administered over 24 hours.

The panel next had regard to the regular medication chart. It considered that there was nothing on this chart which was a clear indication that Furosemide should be given as a continuous infusion over a 24 hour period.

In her witness statement Ms 1 stated '*the Furosemide should have been a slow infusion over 24 hours*'. She also stated '*the prescription did not state the time period*'. In her oral evidence Ms 1 was not clear how she determined that the Furosemide should have been administered over 24 hours.

The panel noted that the Furosemide had been administered at the rate which is stated as safe, given in the monograph for Furosemide.

Given all of this, in particular the lack of evidence of a completed prescription, the panel could not conclude that the Furosemide was prescribed to be given to Patient A over 24 hours. Whilst it is satisfied that Mr McCardle did not check the Furosemide prescription, it was not satisfied that it should have been a slow infusion over a period of 24 hours.

The panel therefore found this charge not proved.

Charge 1.4:

1.4) Allowed the Furosemide to be administered over a one hour period;

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's oral and written witness statements, Mr McCardle's written submissions, the continuous drug infusion chart for Furosemide for Patient A dated 14 October 2017, the monograph for Furosemide, the

patient notes for Patient A dated 14 October 2017 and the regular medication chart for Patient A for 14 October 2017.

The panel noted Mr McCardle's response to this charge is that he did not administer the Furosemide and that he had raised his concerns with Ms 1. The panel has already determined at charge 1.1 that it preferred Ms 1's evidence that Mr McCardle did not raise any concerns with her.

The panel noted that it is not factually disputed that Mr McCardle was the second checker for the administration of Furosemide to Patient A on 14 October 2017 and that he had signed off on the medication being administered. Neither is it factually disputed that the Furosemide was administered to Patient A over a one hour period.

The panel was therefore satisfied that on 14 October 2017, whilst acting as second checker for the administration of 240mg of Furosemide to Patient A, Mr McCardle allowed the Furosemide to be administered over a one hour period.

The panel therefore found this charge proved.

Charge 2.1:

2) On 20 October 2017 whilst preparing and/or administering Clarithromycin for Patient B:

2.1) Incorrectly diluted the Clarithromycin with 10mls of saline solution instead of 10mls of water;

This charge is found proved.

In reaching this decision, the panel took into account Ms 2's oral evidence and written witness statement, as adopted by her, and Mr McCardle's written responses.

Ms 2, in her oral evidence, described an incident on the morning of 20 October 2017. She told the panel that Mr McCardle was preparing Clarithromycin to administer to Patient B and asked her to act as second checker; Mr McCardle told Ms 2 that the Clarithromycin '*looked funny*' and upon investigation Ms 2 discovered that Mr McCardle had prepared the Clarithromycin with 10mls of saline solution rather than 10mls of water as is directed in the monograph. Ms 1 told the panel that they had discarded the medication and remade it according to the directions in the monograph and had administered it to Patient B.

Mr McCardle in his written response denies this charge but goes on to explain that he was corrected by another nurse during the second checker process.

The panel considered there is an agreement between the evidence of Ms 2 and Mr McCardle as to the fact that on 20 October 2017, whilst preparing Clarithromycin for Patient B, Mr McCardle incorrectly diluted the Clarithromycin with 10mls of saline solution instead of 10mls of water.

The panel therefore found this charge proved.

Charge 2.2:

2.2) Administered Clarithromycin at 6p.m. to Patient B, without a second checker;

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague 1 and Ms 2's oral evidence and written witness statement, Mr McCardle's written responses, *NHS Borders Code of Practice for the Control of Medicines Policy* (the Local Policy) and the regular medication chart for Patient B dated 20 October 2017.

Prior to making a finding of fact regarding this charge the panel concluded it was required to determine its interpretation of 'administered'. For the purpose of this hearing the panel considered this to be the direct giving of the medication to the patient, there being a distinction between the preparation of the medication and the giving of medication to a patient.

The panel had regard to the regular medication chart for Patient B and noted that there are two signatures for Clarithromycin being given at 6p.m. on 20 October 2017.

Ms 2 gave evidence to the panel that, whilst she had acted and signed for as second checker for Mr McCardle in the preparation of the 6p.m. prescription of Clarithromycin for Patient B on 20 October 2017, she did not go with Mr McCardle when he gave this medication to Patient B. Ms 2 agreed that this did not comply with the Local Policy but told the panel that it was common practice in the MAU at the time of the incident for second checkers not to witness the giving of the medication to the patient. Ms 2 acknowledged that this was not good practice telling the panel that she had learnt from this incident to always second check the entire medication administration process and that she had changed her practice to reflect this.

Mr McCardle in his written submissions denies this charge and states '*there was an identified second check*'.

When questioned, Ms 2 admitted that whilst she did not go with Mr McCardle to administer the Clarithromycin to Patient B, she did not know if someone else went with him to administer it.

The panel noted Colleague 1's evidence in regards to this charge. Colleague 1 told the panel that Ms 2 was not with Mr McCardle when he administered the Clarithromycin to Patient B and that she did not see a second checker. However, the panel noted that, whilst she was present on the unit at the time of the administration of this medication, Colleague 1 was occupied with administering medication to another patient and was not observing what was happening with Patient B at all times. For example the panel noted that she was unable to confirm, when questioned, whether Mr McCardle had flushed the cannula or not. The panel noted that Colleague 1 was not directly asked whether Mr McCardle administered this medication alone.

The panel noted the Local Policy does not state the second checker must be a nurse and it has heard evidence that Health Care Assistants may be trained to act as second checkers.

The panel considered it had not been established that there was no second checker present when Mr McCardle administered Clarithromycin to Patient B at 6p.m.

The panel therefore found this charge not proved.

Charge 2.3:

2.3) Ignored Patient B's complaint that their skin was sore;

This charge is found proved.

In reaching this decision, the panel took into account Colleague 1's oral evidence and written witness statement, as adopted by her, and Mr McCardle's written responses.

Colleague 1 told the panel that she was attending to another patient on the ward on 20 October 2017 when she heard Patient B complaining to Mr McCardle. Colleague 1 told

the panel that she was close enough to witness the interaction between Mr McCardle and Patient B. She told the panel that Patient B had said '*its sore*' to Mr McCardle in relation to the IV medication being administered. Colleague 1 told the panel that Mr McCardle "l*aughed like [Patient B] was incorrect; like [Patient B] was wrong and he knew better*" and that he backed out of the room saying the Clarithromycin was "*fine, it is going in*" and he would "*come back and check it in a wee while*".

Colleague 1 explained to the panel that once she had finished with her patient about 15 minutes later Patient B asked her to have a look at her arm as it was sore where the Clarithromycin was being administered and Mr McCardle had not returned to check it.

Mr McCardle's position in his written documentation is that he did not ignore Patient B but that he had identified and raised this with colleagues and medical staff. The panel noted there is no evidence that Mr McCardle raised Patient B's complaint of their skin being sore with anyone.

The panel considered that Colleague 1's evidence was clear and consistent from her report on the day of the incident through the local investigation and again in her oral evidence to the panel.

The panel accepted Colleague 1's evidence. The panel considered it to be more likely than not that, on 20 October 2017 whilst administering Clarithromycin to Patient B, Mr McCardle ignored Patient B's complaint that their skin was sore.

The panel therefore found this charge proved.

Charge 2.5:

2.5) Administered the Clarithromycin into Patient B's tissue instead of their vein;

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 1's and Colleague 1's oral evidence and written witness statements and Mr McCardle's written responses.

Mr McCardle in his written submissions states '*As far as I was aware at the time of administration the cannulae [sic] was patent as I had previously checked it with a saline flush*'.

Ms 2 confirmed that she was not present when the Clarithromycin was administered and therefore could not confirm if it had been administered into Patient B's tissue instead of their vein.

Colleague 1 told the panel that Patient B complained as soon as the Clarithromycin infusion was started. However, in the panel's view this could have been due to the incorrect dilution of the Clarithromycin, which Mr McCardle has admitted at charge 2.6. The panel has heard evidence that Clarithromycin can cause pain and irritation when not diluted correctly.

The panel noted there is evidence that there was damage to Patient B's arm which indicated that, at some point, Clarithromycin did go into tissue rather than the vein. However, the panel was not satisfied that the cannula did not move after Mr McCardle had administered the Clarithromycin infusion particularly given that Patient B had experienced pain in the infusion site.

The panel determined that there is no direct evidence that, on 20 October 2017, Mr McCardle administered Clarithromycin into Patient B's tissue instead of their vein. On the balance of probability the panel was not satisfied that there was sufficient evidence to find this charge proved.

The panel therefore found this charge not proved.

Charge 3.1:

3) On 22 October 2017 whilst administering a Parvolex infusion to Patient C:

3.1) Administered the drug independently without a second checker;

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 6's oral evidence and witness statement, as adopted by her, Mr McCardle's written submissions, Patient C's medicine chart and a photograph of the IV bag containing Parvolex.

Ms 6 confirmed to the panel that she was the second checker for Mr McCardle administering the Parvolex infusion to Patient C on 22 October 2017 but that, whilst she checked the medication preparation and signed the chart, she did not go with Mr McCardle to give the Parvolex to Patient C. The panel noted that she confirmed her signature as second checker on both Patient C's medicine chart and the sticker on the IV bag of Parvolex.

The panel considered it had not been established that there was no second checker present when Mr McCardle administered Parvolex to Patient C as in charge 2.2 above.

The panel therefore found this charge not proved.

Charge 3.2:

3.2) Pierced an incorrect entry point on the infusion bag of Parvolex;

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 4's, Ms 5's and Ms 6's oral evidence and witness statements, as adopted by them, Mr McCardle's written submissions, Patient C's medicine chart and several photographs of the IV bag containing Parvolex.

Both Ms 5 and Ms 6 gave conflicting evidence in respect of the hole in the bag of Parvolex. Ms 5 took the panel through how the ports on the IV bag functioned. When questioned, Ms 5 confirmed that she could not recall actually seeing the hole but that she thought you would be able to see it from the top of the bag. Ms 6 said that she did not remove the tape to look but she imagined there was a hole there.

Ms 4, in her witness statement, states '*When [Mr McCardle] went to put the drug up, something happened, I don't know what it was. It looks like the injection port was punctured as [he] tried to insert the infusion line into the injection port. [He] denies that however*.' Further she states '*We did try and find out exactly what happened but couldn't*'.

The panel considered the evidence from Ms 4, Ms 5 and Ms 6 to be confused and contradictory in respect of this charge. None of these witnesses was able to say that the incorrect port had been pierced on the infusion bag. The panel noted that all three of these witnesses could only offer hearsay evidence and that there was no direct evidence in relation to this charge.

Mr McCardle in his written evidence states he '*used a large bore needle when putting the medication into the bag*'. Further he states '*I didn't put the insert line into the wrong port… it very obviously doesn't fit.*' The panel considered Mr McCardle's explanation to be plausible. Further his position has remained consistent with his statements at the local investigation level.

In the circumstances the panel determined there was not sufficient evidence to conclude that, on 22 October 2017, whilst administering a Parvolex infusion to Patient C Mr McCardle pierced an incorrect entry point on the infusion bag.

The panel therefore found this charge not proved.

Charge 4:

4) Between August and October 2017 responded rudely to A Foundation doctor in regards to prescribing medication.

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 1's oral and written witness statements and Mr McCardle's written representations.

Mr McCardle, in his written submissions, denies any knowledge of this incident.

Ms 1 told the panel of an incident in which she witnessed Mr McCardle arguing with a foundation year doctor. In her oral evidence Ms 1 said that she did not hear the start of the incident but arrived back on the ward to raised voices. When questioned Ms 1 could not recall what the argument was about or whether it had been to do with prescribing medication.

The panel noted that Ms 1 is the only witness to this incident and her account was vague both in her oral evidence and in her witness statement. The panel noted that the incident was not reported at the time by either Ms 1 or the doctor involved and only

came to light during the investigation of the medication administration errors detailed in charges 1, 2 and 3.

The panel considered that the evidence was not sufficiently satisfactory to determine that, between August and October 2017, Mr McCardle responded rudely to A Foundation doctor in regards to prescribing medication.

The panel therefore found this charge not proved.

Charge 6:

6) On 20 October 2017 intimidated Colleague 1 in that you:

6.1) Used words to the effect of “You’re going to write this really? Really?”

6.2) Followed Colleague 1 around the unit and used words to the effect of “We need to talk.”

This charge is found proved in its entirety.

Having heard and read the evidence in respect of this charge the panel determined it most appropriate to consider the whole of charge 6 together.

In reaching this decision, the panel took into account Colleague 1’s oral evidence, her witness statement and local investigation statement, the transcript of a telephone conversation on 20 October 2017 between Colleague 1 and the agency she was employed with, and Mr McCardle’s written submissions.

The panel noted the contents of the telephone transcript in which Colleague 1 clearly states ‘*he [Mr McCardle] was being quite intimidating and he was following me around*

the ward'. She went on to say '*he was coming in between [Colleague 1 and a patient's relative] saying "we need to discuss this; we need to discuss this", following me around the ward*'. Further Colleague 1 said '*he was like, "Really? Really?", and sort of rolling his eyes at me and waving the notes in front of me*.'

Colleague 1, in her oral evidence, told the panel in detail of the incident involving Mr McCardle on 20 October 2017. She told the panel that she felt intimidated by his manner and behaviour, that he "*caught me off-guard*" and that he was "*aggressive*" and had "*frightened*" her.

The panel considered that Colleague 1 gave clear and compelling evidence in respect of this charge. It noted that her evidence has remained consistent from the transcript of the discussion which took place on the same day as the incident, to her witness statement and her oral evidence given to the panel at this hearing. The panel considered that Colleague 1 had clearly been upset and distressed by this incident and accepted that she had been intimidated.

Mr McCardle, in his written submissions refutes this charge. He states that he asked Colleague 1 for patient notes but that she had been unhappy to engage or explain the circumstances around the error. He states that Colleague 1 burst into tears and he walked away. Mr McCardle claims that he apologised to Colleague 1 if he had '*come across in any way that may have upset her*' and that Colleague 1 had accepted this. During her oral evidence, Colleague 1 was told that Mr McCardle said he had apologised and that she had accepted this, she stated "*No absolutely not… he is mistaken*" and explained that she had been allowed to leaved her shift before Mr McCardle finished so that he "*could not make [her] feel uncomfortable*".

On balance, the panel considered Colleague 1's evidence to be more compelling than the written evidence of Mr McCardle in regards to this incident. The panel considered it more likely than not that Mr McCardle had pursued Colleague 1 in the manner she

described. Further, the panel considered it more likely than not that Mr McCardle had used words to the effect of those detailed in charge 6.1 and 6.2.

The panel concluded when in considering this charge in its entirety it was more likely than not that Mr McCardle did intimidate Colleague 1 by following her around the unit and using words to the effect of "*You're going to write this really? Really?*" and "*We need to talk*".

The panel therefore found this charge 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 Mr McCardle's 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.

In his submissions Mr Drinnan invited the panel to take the view that Mr McCardle's actions amount to a breach of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code). He then directed the panel to specific paragraphs and identified where, in the NMC's view, Mr McCardle's actions amounted to misconduct. He further referred the panel to the Local Policy and where, in his view, this had been breached by Mr McCardle.

Mr Drinnan referred the panel to Mr McCardle's nursing registration history, given that it is referenced in his written submissions. Mr Drinnan explained to the panel that Mr McCardle had received a striking-off order in 2009 for matters which were similar to those being dealt with by this hearing, which occurred in 2007. Mr Drinnan told the panel that Mr McCardle had then successfully applied to be restored to the NMC

register in 2015. He provided the panel with documentation in respect of the NMC hearings in 2009 and 2015.

Mr Drinnan 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*'. He further referred the panel to the case of *Johnson & Maggs v NMC [2013]* EWHC 2140 (Admin).

Mr Drinnan reminded the panel of the risks which had been talked to by the witnesses in regards to Mr McCardle's failings and the harm which could have been caused to patients. Further, he submitted that the behaviour exhibited by Mr McCardle was far below the standards expected of a registered nurse.

He 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. Mr Drinnan referred the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011]* EWHC 927 (Admin) and *Nandi v GMC [2004]* EWHC 2317 (Admin).

Mr Drinnan submitted that Mr McCardle undoubtedly put patients at unwarranted risk of harm by failing to check the prescription of Patient A and although in this instance there was no patient harm there was a risk of harm. Similarly there was a risk of harm to Patient C due to Mr McCardle's "*slapdash attitude*". Mr Drinnan drew the panel's attention to the actual harm caused to Patient B, who complained of sore skin and Mr McCardle ignored this. He submitted this amounted to a breach of a fundamental tenet of the profession.

Mr Drinnan submitted to the panel that Mr McCardle's behaviour towards Person 1, a patient's relative, and to Colleague 1 in terms of his lack of empathy and aggressive and intimidating behaviour had brought the profession into disrepute.

Mr Drinnan invited the panel to consider the case of *Pillai v GMC [2009]* EWHC 1048 (Admin). He submitted that this case enabled the panel to take into account the attitude of a practitioner when considering whether their fitness to practise is impaired. He submitted the panel may consider Mr McCardle's lack of attendance or engagement with the NMC was relevant here and could be viewed as an evasion of responsibility. He invited the panel to consider whether there was evidence of an attitudinal concern and, if so, whether this could be remediated.

In closing, Mr Drinnan invited the panel to conclude that Mr McCardle's fitness to practise is impaired not only on the grounds of public protection but also on the ground of public interest.

The panel has accepted the advice of the legal assessor which included reference to a number of judgments which are relevant, these included: *Roylance*, *Grant* and *Cohen v GMC [2008]* EWHC 581 (Admin). The panel noted Mr Drinnan's submissions in regard to the case of *Pillai* and accepted the further advice of the legal assessor in relation to this case. The panel was not persuaded that *Pillai* was of relevance in respect of the non-attendance of Mr McCardle in this case.

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, Mr McCardle's 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 Mr McCardle's actions did fall significantly short of the standards expected of a registered nurse, and that his 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

2.1 work in partnership with people to make sure you deliver care effectively

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages

8.2 maintain effective communication with colleagues

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

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

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague… who wants to raise a concern

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

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

To achieve this, you must:

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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

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 in respect of the clinical aspects of this case, with the exception of charge 2.1, Mr McCardle's actions taken together did amount to a finding of misconduct. The panel noted that these errors related to fundamental clinical nursing skills in respect of which Mr McCardle had completed training. Further, the panel considered that due to the repetitive nature of the errors within a short period of time there was a significant potential for serious harm; there was nothing to indicate Mr McCardle had learnt from previous incidents.

The panel then considered the behavioural and attitudinal concerns raised in charges 5 and 6. The panel considered it to be a serious departure from the standards expected of a registered nurse to behave in the way as described towards Person 1 who was a terminally ill patient's relative. Further the panel considered that Mr McCardle's behaviour, resulting in significant distress for Colleague 1, was completely unacceptable.

The panel therefore found that Mr McCardle's actions did fall seriously short of the conduct and standards expected of a nurse and therefore amounted to misconduct.

Decision on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. 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 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 her 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 having heard submissions, principally from Ms McDonald, 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 he/she:

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

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

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

d. ...

The panel finds that limbs a, b and c of the 'Grant test' are engaged in this case. The panel considered that Mr McCardle's actions had put patients at unwarranted risk of harm on several occasions in October 2017 and in the case of Patient B caused actual harm. The panel noted the similarity between these failings and the mistakes that formed the basis of the previous case before the NMC which, in the panel's view, suggests that Mr McCardle has not learnt from these past errors.

The panel considered that the type of behaviour described in charges 5 and 6 towards a terminally ill patient's relative, in the presence of the patient, and towards a colleague had brought the profession into disrepute. Nurses are expected to act professionally at all times and to treat people with kindness, respect and compassion.

In the panel's view Mr McCardle has in the past breached, and is liable in the future to breach, the fundamental tenets of the nursing profession.

Regarding insight, the panel considered that Mr McCardle's insight is, at best, superficial. The panel noted the reflective piece provided for this hearing and the reflective piece provided for Mr McCardle's restoration hearing in 2015 are similar in nature. The panel considered Mr McCardle to have demonstrated a low level of insight given that he has been in this position before. Mr McCardle has expressed some regret

about what has happened and has admitted some of his errors but the panel considered he has also made excuses and attempted to justify his actions rather than take ownership of his mistakes.

The panel considered Mr McCardle has shown very little recognition of the distress and difficult circumstances Person 1 was experiencing at the time of the incident detailed at charge 5 and, in his written submissions, he has demonstrated a lack of empathy and understanding of this. The panel heard from Person 1 and Ms 3, who was a direct witness to this incident, of the distress Mr McCardle's behaviour caused. The panel noted Mr McCardle had not apologised to Person 1 and in his written submissions, whilst acknowledging he '*managed this situation poorly*' he again offers excuses for and attempts to justify his unprofessional behaviour.

The panel considered Mr McCardle's reflective statement provided for this hearing and considered that he has not demonstrated any recognition of how these events affected others involved, including his patients, their relatives, his colleagues and the reputation of the hospital and his profession.

In its consideration of whether Mr McCardle has remedied his practice. The panel took into account Mr McCardle's reflective statement. The panel considered that it shows very little in the way of remediation, particularly when compared to the reflective statement produced for his restoration hearing. The panel noted that at his restoration hearing Mr McCardle provided evidence and assurance that he had remediated the concerns in his practice. However, he has gone on to make further serious medication errors less than three years after he was restored to the register. The panel noted that Mr McCardle has produced a certificate for a '*Drug Administration and Calculations Workshop*' dated 23 April 2018 but has not produced evidence of any other study relevant to IV medication administration. Further, the panel noted it has been told by Ms 6 that Mr McCardle was up to date with all his training at the time of the incidents. In addition Mr McCardle had completed his return to practice training in 2015. However,

the panel was of the view that Mr McCardle has not remediated the failings identified in his practice.

The panel is of the view that there is a risk of repetition based on Mr McCardle's lack of insight and remediation. 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/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. Mr McCardle's actions put his patients at unwarranted risk of harm, he has failed to take responsibility for these or demonstrate he has remediated the failings in his practice. Further the panel considered Mr McCardle's behaviour towards Person 1 and Colleague 1 to be unprofessional and to have brought the profession into disrepute.

The panel determined that, in this case, a finding of impairment on public interest grounds was required.

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

Determination on sanction:

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

In his submissions Mr Drinnan took the panel through the aggravating factors and mitigating factors he had identified in this case.

Mr Drinnan submitted that Mr McCardle had demonstrated a pattern of conduct which had put patients at a risk of harm and had demonstrated a low level of insight; he had made excuses and attempted to justify his actions. Mr Drinnan submitted that Mr McCardle should have demonstrated an "*extra layer of care*" given his previous striking-off order and that he had gone on to repeat matters after being given a second chance. Mr Drinnan submitted that there was strong public interest in this case given the damage caused to the reputation of the profession as well as the public protection issues.

Mr Drinnan drew the panel's attention to the case of *Bolton v The Law Society [1994]* 1WLR 512 in which it was determined that matters of personal mitigation carry less weight than they would in criminal court. In light of this Mr Drinnan submitted that, whilst the panel can consider Mr McCardle's health condition as a factor in mitigation, it should attach less weight to this.

In reaching this decision, the panel has had regard to all the evidence that has been presented in this case, as well as the submissions by Mr Drinnan. The panel accepted the advice of the legal assessor.

The panel acknowledged the NMC Sanction Bid of a striking-off order, but was not bound by such a bid, and has exercised its independent judgement. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and is intended to protect the patients and public by restricting the practice of a registered nurse. Although not intended to be punitive in its effect, any sanction may have such unintended consequences. The panel had careful regard to the Sanctions Guidance (SG) published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel has also taken account of the aggravating and mitigating factors in this case.

The aggravating factors which the panel took into account, in particular, were: the risk of harm to patients and the actual harm caused to Patient B; the repetitive nature of Mr McCardle's errors over a short period of time coupled with a pattern of conduct going back to 2007 and his previous fitness to practise history; the attitudinal and behavioural concerns identified by the panel in terms of his aggressive and intimidating behaviour towards a colleague and his unprofessional behaviour towards a patient's relative in front of the patient; Mr McCardle's, at best, superficial insight in which there is a lack of evidence of insight into the impact of his actions on his patients, their relatives, his colleagues and the reputation of both the Hospital and the profession.

The mitigating factors which the panel took into account, in particular, were that Mr McCardle has engaged with these proceedings to the best of his ability, taking into account his written submissions and evidence provided of his health condition. Further Mr McCardle admitted some of the charges from the outset, has provided limited reflection on his actions and has accepted some responsibility for these errors albeit on occasion with qualifications and attempting to justify and shift blame for these failings.

The panel is aware that it can impose any of the following sanctions; take no further action, make a caution order for a period of one to five years, make a conditions of practice order for no more than three years, make a suspension order for a maximum of one year, or make a striking-off order.

The panel considered the potential sanctions in ascending order of restrictiveness.

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 has already found that Mr McCardle's fitness to practise is impaired on the grounds of public interest as well as on public protection grounds. As such, the panel concluded 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 SG, 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 Mr McCardle's actions were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. In addition, having found Mr McCardle's fitness to practise is impaired on public protection grounds a caution order would provide no restriction on his practice. 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 Mr McCardle's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel noted that Mr McCardle has failed to demonstrate learning from his previous mistakes and the previous fitness to practise proceedings. Despite having been afforded a second chance by the restoration hearing and completing a return to practice course and additional medication administration training Mr McCardle has gone on to make further serious medication administration errors. The panel was therefore of the view that the concerns identified in this case are unlikely to be addressed by further retraining. In addition there are attitudinal and behavioural issues in this case which could not be addressed by placing restrictions on his practice. The panel is therefore of the view that there are no practical or workable conditions that could be formulated, given the nature of this case. Furthermore the panel concluded that the placing of conditions on Mr McCardle's registration would not adequately address the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG indicates that a suspension order would be appropriate where (but not limited to):

- 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 noted that Mr McCardle's actions were not an isolated incident but rather demonstrated a pattern of behaviour over a period of time which put patients at risk of suffering harm and in one case caused actual harm. The panel considered that there is limited evidence of remorse and little to no evidence of insight into the distress and potential harm Mr McCardle may have caused to patients in his care or to their relatives. The panel considered that Mr McCardle's actions had demonstrated attitudinal issues as highlighted by his unprofessional behaviour towards Person 1 and by his intimidation of and aggression towards Colleague 1. Further the panel has identified that there is a risk of repetition of this behaviour based on Mr McCardle's lack of insight and remediation.

The panel has taken into account the mitigation identified, in particular Mr McCardle's reference to his health condition and how this may have impacted on his actions at the time of the incidents.

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

Balancing all of these factors, the panel has determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

- Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?
- Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?
- Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?

The panel was of the view that the findings in this particular case, especially in light of the previously imposed striking-off order, demonstrate that Mr McCardle's actions were extremely serious and had the potential to cause significant harm. Mr McCardle's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with his remaining on the register. The panel considered that to allow him to continue practising would undermine public confidence in the profession and in the regulatory process. Further the panel has nothing before it to suggest that if Mr McCardle were to remain on the register that his practice would improve. The panel was mindful of the fact that Mr McCardle had previously been given an opportunity to get back on the register which he took but this case has demonstrated that he has not learnt from his past experiences.

Balancing all of these factors and after 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 Mr McCardle's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order is 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.

Accordingly the panel is satisfied that a striking off order is necessary on the grounds of both public protection and public interest.

The panel was mindful of the potential impact that such an order may have on Mr McCardle but taking full account of the important principle of proportionality, the panel was of the view that the interests of the public outweighed Mr McCardle's interests.

The panel, therefore, directs the Registrar to strike Mr McCardle's name from the Register. He may not apply for restoration until five years after the date that this decision takes effect.

Determination on Interim Order

The striking off order will not take effect until the end of the appeal period (28 days after the date on which the decision letter is served) or, if an appeal has been lodged, before the appeal has concluded.

The panel considered the submissions made by Mr Drinnan that an interim suspension order should be made to cover the 28 day appeal period. He submitted that this was appropriate given the panel's findings.

The panel heard and accepted the advice of the legal assessor and took account of the guidance issued to panels by the NMC when considering interim orders and the appropriate test as set out at Article 31 of The Nursing and Midwifery Order 2001. It may only make an interim order if it is satisfied that it is necessary for the protection of

members of the public, is otherwise in the public interest or is in Mr McCardle's own interests.

The panel considered that an interim order is required for the protection of the public and is otherwise in the public interest. It concluded that to not make such an order would be incompatible with the panel's earlier findings and with the substantive sanction that it has imposed. The panel first considered whether it was appropriate to impose an interim conditions of practice order, but considered that no workable conditions could be formulated as identified at the sanction stage.

Therefore the panel decided to impose an interim suspension order for the same reasons as it imposed the substantive order and, having accepted Mr Drinnan's submissions, to do so for a period of 18 months in light of the likely length of time that an appeal would take to be heard if one was lodged.

The panel recognises the impact that an interim suspension order may have on Mr McCardle, however the panel had no information as to the impact of such an order on him. However, it concluded the public interest outweighed his in this regard.

The effect of this order is that, if no appeal is lodged, the substantive striking off order will come into effect 28 days after notice of the decision has been served on Mr McCardle and the interim suspension order will lapse. If an appeal is lodged then the interim suspension order will continue until the appeal is determined.

The panel's decisions will be sent to Mr McCardle in writing.

That concludes this determination.