Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

2-10 December 2019 [Part-heard]

7-9 January 2020 [Resumed]

Nursing and Midwifery Council, Temple Court, 13a Cathedral Road, Cardiff, CF11 9HA
[2-10 December 2019]
Holiday Inn Cardiff City Centre, Castle Street, Cardiff CF10 1XD
[7-9 January 2020]

Name of registrant:	Delroy Owen
NMC PIN:	90D0106W
Part of the register:	Registered Nurse – Mental health nursing
Area of Registered Address:	Wales
Type of Case:	Misconduct
Panel Members:	Jane Kivlin (Chair – Registrant member) Kevin Connolly (Lay member) Catherine Cooper (Registrant member)
Legal Assessor:	Charles Parsley
Panel Secretary:	Vicky Green
Registrant:	Present and represented by Darren Snow, Counsel instructed by the Royal College of Nursing
Nursing and Midwifery Council:	Represented by Siobhan Caslin, Case Presenter [2-10 December 2019] Represented by Helen Guest, Case Presenter [7-9 January 2020]
Facts proved:	3)a), 3)b), 4)a, 4)b), 5)a), 5)b), 6)
Facts proved by admission:	1, 2)a), 2)b), 2)c), 2)d), 2)e)

Fitness to practise:	Impaired
Sanction:	Striking off order
Interim Order:	Interim suspension order – 18 months

Details of charge

That you, a registered mental health nurse:

1) Administered [PRIVATE] to Patient A on or about 31 March 2017 when it was not due until 13 April 2017 *[Proved by admission]*

2) Did not administer [PRIVATE] to Patient A on or around the following dates:
   a) 13 April 2017 *[Proved by admission]*
   b) 21 April 2017 *[Proved by admission]*
   c) 11 May 2017 *[Proved by admission]*
   d) 25 May 2017 *[Proved by admission]*
   e) 8 June 2017 *[Proved by admission]*

3) Did not escalate/adequately escalate the fact that Patient A had not received any [PRIVATE] between 13 April 2017 and 12 June 2017 (which were intended to be given fortnightly),
   a) To your line manager
   b) To Patient A's consultant psychiatrist

4) Following failed visits or attempts to administer [PRIVATE] to Patient A you did not
   a) attempt to call/contact him on each occasion
   b) did not attempt to call/contact a relative of Patient A on each occasion

5) Did not escalate/adequately escalate the fact that you had not been in contact with Patient A since approximately 31 March 2017
   a) To your line manager
   b) To Patient A's consultant psychiatrist

6) Your actions in any/all of charges 1,2,3,4 and 5 contributed to the death of Person B

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

Decision on the findings of facts and reasons

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Ms Caslin, on behalf of the NMC and those made by Mr Snow on your behalf.

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 heard oral evidence from four witnesses called on behalf of the NMC. In addition, the panel heard oral evidence from you.

Witnesses called on behalf of the NMC were:

Ms 1 – Community Psychiatric Nurse Team Leader employed by the Community Health Team at Cwm Taf University Health Board (the Board);
Mr 2 – Head of Nursing at Abertawe Bro Morgannwg University Health Board;
Dr 3 – Consultant Psychiatrist at the Board;
Mr 4 – Senior Nurse in adult mental health at the Board.

Decision and reasons on application pursuant Rule 19

Before you gave evidence Mr Snow made an application pursuant to Rule 19 of the Rules for parts of the hearing to be held in private on the basis that there would be reference to your health.

Ms Caslin did not oppose this application and agreed that any reference to your health should be heard in private.

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.

Having heard that there will be reference to your health, the panel determined to hold such parts of the hearing in private. The panel determined to rule on whether or not to go into private session in connection with your health as and when such issues are raised.

Additional evidence

During the facts stage, the panel was alerted to the possible existence of further, potentially relevant evidence.

Ms Caslin and Mr Snow agreed to the admission of a Police witness statement made by a friend of Person B.

Mr Snow submitted that you sent emails about the care of Patient A which have not been included in the bundle. He also submitted that there are missing entries from FACE records.

Following the panel directions, Ms Caslin stated that the NMC have made further, but unsuccessful, efforts to obtain these additional documents from the Board. She drew the panel's attention to a number of emails between the Board and the NMC in which it was confirmed that there were no further entries made on FACE and all entries were provided in the NMC bundle.

In your oral evidence you asserted that you had a previously unblemished nursing record. Ms Caslin drew the panel's attention to the implications of that statement and Mr Snow conceded that, in these circumstances the panel should have sight of some previously redacted paragraphs in Ms 1's statement, in which she referred to complaints and concerns about your past conduct.

The panel accepted the advice of the legal assessor.

The panel also considered that the Police witness statement of Ms 5 provided additional background to the incident that occurred on 12 June 2017. It would attach what weight it deemed appropriate when it carried out its assessment of all of the evidence before it.

Witness assessment

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from, including you.

The panel was of the view that Ms 1, on a professional level, was a credible and reliable witness. She was consistent with her statements and her evidence was supported by contemporaneous records. On occasions, in response to questions about her personal responsibility, Ms 1 presented as being defensive and she appeared reluctant to accept any broader responsibility for failings in the care provided to Patient A. While the panel acknowledged that giving evidence can be a worrying experience, it was of the view that Ms 1's exclamation when her evidence concluded was wholly inappropriate in view of the sensitive circumstances of the case and the presence of members of the public.

Mr 2's evidence focussed on the narrow investigation solely into your actions. He tried his best to assist the panel and accepted the limitations of his investigation. The panel considered that Mr 2 was a credible and reliable witness.

The panel found Dr 3's evidence to be largely credible, particularly in relation to his diagnosis and treatment of Patient A, although it noted some inconsistencies between the evidence of Dr 3 and Ms 1. Dr 3, in his evidence, appeared reluctant to accept any broader responsibility for failings in the care provided to Patient A.

Mr 4, in his evidence, tried his best to assist the panel but was of limited assistance because of the restricted scope of the terms of reference for his chronology. The panel considered that Mr 4 was a credible and reliable witness.

The panel was of the view that you were unclear in your evidence and, at times, your evidence evolved and changed. Some of your evidence was contradictory, your memory appeared selective and you were evasive in answering questions that dealt with key issues. The panel accepted that memory can be affected due to the passage of time but it was of the view that overall you were not a credible or reliable witness.

Background

The charges arose whilst you were employed by the Board as a Band 6 Community Psychiatric Nurse (CPN) and Care Co-ordinator (CC). A CPN is a mental health nurse who works within the community to try to prevent the need for hospital admission. The CPN provides support to patients in their own home which includes education and monitoring of their overall mental and physical health needs, treatment and crisis management. Any mental health professional can act as a CC (psychiatrists, social workers, psychologists, occupational therapists and registered nurses). You were the CPN for Patient A and had been since about May 2016 and took over the role of CC for Patient A in January 2017.

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

The panel's findings on facts

At the start of this hearing you admitted the following charges:

1) Administered [PRIVATE] to Patient A on or about 31 March 2017 when it was not due until 13 April 2017

2) Did not administer [PRIVATE] Patient A on or around the following dates:
   a) 13 April 2017
   b) 21 April 2017
   c) 11 May 2017
   d) 25 May 2017
   e) 8 June 2017

These charges were therefore announced as proved. While the panel accepted your admission to charges 1 and 2, it made the following observations and findings in respect of the context in which you admitted them.

Charge 1):

1) Administered [PRIVATE] to Patient A on or about 31 March 2017 when it was not due until 13 April 2017

Dr 3, in his evidence, told the panel that the [PRIVATE] was administered to Patient A on 29 March 2017 before he was discharged. This was recorded on Patient A's notes on the FACE recording system.

In your evidence, you told the panel that you were present for the multi-disciplinary team meeting, held prior to Patient A's release from hospital on 29 March 2017. During this meeting it was decided that Patient A would receive his [PRIVATE] before he was discharged from the Ward. [PRIVATE]. You said that you left the meeting before it concluded, and you left with the understanding that it was agreed that you would administer [PRIVATE] to Patient A during a home visit. You visited Patient A at his home on 31 March 2017 and administered the depot. You accepted that you did not check the FACE records before administering [PRIVATE] to Patient A.

The panel accepted your explanation for erroneously giving the [PRIVATE] depot on 31 March 2017 despite it being documented on the prescription chart *'due 13/4/17'*. You did not check Patient A's notes on FACE, where it was recorded that the [PRIVATE] depot had been administered before he was discharged on 29 March 2017. The panel noted that FACE records were not available to you once you were out in the community, but you could have checked these records prior to your visit.

Charge 2):

2) Did not administer [PRIVATE] to Patient A on or around the following dates:
    a) 13 April 2017
    b) 21 April 2017
    c) 11 May 2017
    d) 25 May 2017
    e) 8 June 2017

Having regard to the evidence before it, namely the drug chart, the panel considered the dates set out in charge 2. The panel noted that if a dose of [PRIVATE] was missed or late, then the precise dates as set out above would not apply and the subsequent date would change to a later date. Notwithstanding this, the panel accepted your admission on the basis that five fortnightly doses were missed during the period in question. The panel noted that had you administered the depot injections regularly as prescribed, you would have had the opportunity in your capacity as Patient A's CC to assess him.

The panel considered each of the remaining charges and made the following findings:

Charge 3)a):

3) Did not escalate/adequately escalate the fact that Patient A had not received any of the [PRIVATE] injections between 13 April 2017 and 12 June 2017 (which were intended to be given fortnightly),
   a) To your line manager

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1, the caseload management session notes dated 16 May 2017 and your evidence.

You attended the caseload management meeting with Ms 1, your line manager on 16 May 2017. The following notes were entered contemporaneously in relation to Patient A:

[PRIVATE]

In the weighting matrix *'SS'* was recorded. This means that you reported that Patient A was in a stable condition and that his was a classed as a simple case.

In your evidence you told the panel that in these meetings with Ms 1, you could see her computer screen and what was being typed. You also confirmed that after this meeting you were sent a final draft of the caseload management session notes, which you agreed were an accurate reflection of your discussion.

The panel noted that the only record of you mentioning to Ms 1 that Patient A's [PRIVATE] depots had been delayed was on 16 May 2017. The panel was of the view that, although you disclosed to Ms 1 that you were *'having difficulty'* in contacting

Patient A and administering the depot, you did not provide full disclosure. By 16 May 2017, you had failed to administer three of the doses of [PRIVATE] as prescribed.

The panel noted that in her statement, Ms 1 had considered that you had lied to her in 2015 about having visited a patient for 8 months in 2015 when you had not done so. The comment attributed to you in the notes that Ms 1 made in 2017 clearly implied that you were seeing Patient A and that he was receiving the prescribed injections, albeit a few days late. This was patently untrue. The panel concluded that in making this statement you deliberately misled Ms 1 and you did not escalate in any sense the fact that Patient A had not received any due medication.

The panel concluded that you did not adequately escalate to your line manager the fact that Patient A had not received any of the [PRIVATE] Depot 400mg injections between 13 April 2017 and 12 June 2017. Accordingly, the panel found this charge proved.

Charge 3)b):

3) Did not escalate/adequately escalate the fact that Patient A had not received any of the [PRIVATE] injections between 13 April 2017 and 12 June 2017 (which were intended to be given fortnightly),
   b) To Patient A's consultant psychiatrist

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 3 (Patient A's consultant psychiatrist) the SWIFT record dated 5 May 2017 and 2 June 2017 and your evidence.

The SWIFT entry on 5 May 2017 you recorded:

'Called at Patient A's this morning – no response again. Informed Dr [3].'

In your oral evidence you told the panel that Dr 3 said *'what do you expect, he's a druggie'* or words to that effect. Dr 3 told the panel he had no recollection of this.

The panel had regard to the SWIFT record dated 2 June 2017 in which you noted the following:

> *'Discussed [Patient A] with [Dr 3]. To continue to attempt to contact and to leave notes. If no response in 1 month to refer to Assertive outreach team under the Difficult to Engage Heading.'*

In his evidence, Dr 3 told the panel that you had not spoken to him about Patient A until the conversation on 2 June 2017. Dr 3 also told the panel that you did not make him aware that you had not administered any of the due doses of [PRIVATE] since Patient A was discharged.

Whilst not directly linked to this charge, the panel noted that in your statement to the Police, you said that you had escalated Patient A's missed depots and lack of contact with Patient A to the outreach team. You did not refer to this in the local investigation carried out by the Board in January 2018. In your oral evidence you told the panel that you did escalate your concerns to the outreach team soon after your discussion with Dr 3 on 2 June 2017. The panel noted that there was no evidence to support your assertion. The panel therefore concluded that, on the balance of probabilities, you did not escalate the missed depots and lack of contact to the outreach team.

In your evidence you told the panel that you escalated that you had been unable to administer the [PRIVATE] depot to Patient A. Initially you said that you told Dr 3 that you had missed *"quite a few"* of the depots, then later when you were prompted, you said that you told Dr 3 that Patient A had *"missed them all"*. The panel noted the inconsistencies in your evidence and that there was no evidence to support your assertion.

The panel preferred the evidence of Dr 3, and considered that it was more likely than not that you did not escalate the fact that Patient A had not received any of the [PRIVATE] Depot 400mg injections, between 13 April 2017 and 12 June 2017 to Dr 3.

Charge 4)a):

4) Following failed visits or attempts to administer the [PRIVATE] Depot 400mg to Patient A you did not
   a) attempt to call/contact him on each occasion

This charge is found proved.

In reaching this decision, the panel took into account your entries in Patient A's SWIFT records, your diary entries and your evidence.

The panel noted that your failure to contact Patient A meant that you had no opportunity to assess his condition.

In your evidence, you told the panel that following failed visits to Patient A, you would always post a note to say that you had attended the property. You said that the note contained a prompt for Patient A or Person B to contact you on your office landline telephone number. You told the panel that you did not try to call Patient A because, from past experience, you said that he was not contactable by telephone.

You told the panel that you would make extra visits to see if Patient A was home when you visited another patient who lived nearby. You told the panel that this information would be recorded in your diary. These additional attempts were not recorded in your diary and, upon further questioning, you said that you would have recorded this in your note book. Since you are now retired, you said that you do not have access to your note

book. The panel had no evidence before it that the note book had been made available as evidence to the clinical review or the investigation carried out by Mr 2.

The panel had sight of Patient A's SWIFT records. It noted that you made an entry on 31 March 2017, when you administered the [PRIVATE] depot. In two further entries made on 4 April 2017 and 19 May 2017, you recorded that you had left a note. However, on 7 April 2017, 13 April 2017 and 5 May 2017 you recorded that you had visited Patient A but you did not record that you had left a note.

The panel also had sight of SWIFT entries entered by you in respect of Patient A in 2016. The panel noted that in 2016 you made more detailed notes on the occasions you were unable to contact Patient A, and you recorded what action you had taken. Based on these records in 2016, the panel did not accept that you did try to contact Patient A in 2017, as you had not recorded your attempts to contact him in your notes as you had done in 2016.

The panel noted that, by your own admission, you did not attempt to call Patient A when he was not home. The panel concluded that you did not attempt to contact him on each occasion after the failed visits. Accordingly, the panel found this charge proved.

Charge 4)b):

4) Following failed visits or attempts to administer the [PRIVATE] Depot 400mg to Patient A you did not
   b) did not attempt to call/contact a relative of Patient A on each occasion

This charge is found proved.

In reaching this decision, the panel took into account your entries in Patient A's SWIFT records, your diary entries and your evidence.

In your evidence you told the panel that you did not attempt to contact Person B by telephone. You said that she was not contactable by telephone. You said that following failed visits to Patient A, you would always post a note to say that you had attended the property. You said that the note contained a prompt for Patient A or Person B to contact you on your office landline telephone number. You told the panel that you would often see Person B at the bus stop when you were driving past to visit another patient who lived close to where Patient A and Person B lived. You said that if the bus stop was not busy you would often stop to speak with Person B and discuss Patient A. You did not record this contact in Patient A's notes or your diary.

You told the panel that you would make extra visits to see if Patient A was home when you visited another patient who lived nearby. You told the panel that this information would be recorded in your diary. These additional attempts were not recorded in your diary and, upon further questioning, you said that you would have recorded this in your note book. Since you are now retired, you said that you do not have access to your note book. The panel had no evidence before it that the note book had been made available as evidence to the clinical review or the investigation carried out by Mr 2.

The panel had sight of Patient A's SWIFT records. The panel noted from your three entries documenting attempts at contact, that you only recorded that you had left a note on one occasion.

The panel also had sight of SWIFT entries entered by you in respect of Patient A in 2016. The panel noted that in 2016 you made more detailed notes on the occasions you were unable to contact Patient A; and you recorded what action you had taken. Based on these records in 2016, the panel considered that it was not plausible that you did try to contact Person B in 2017. You had not recorded your attempts to contact her in your notes as you had done in 2016. Further the panel noted that Person B had previously engaged with you and the service.

The panel noted that, by your own admission, you did not attempt to call Person B following the failed visits. The panel determined that you did not attempt to contact Person B following the failed visits or to discuss the missed [PRIVATE] depots. [PRIVATE] The panel was of the view that, given all of the above, if you had attempted to contact Person B you would have been able to reach her at some point between April-June 2017. Furthermore, it was likely that she would have been supportive in facilitating the administration of Patient A's depots.

Therefore the panel finds your suggestions implausible that you made such attempts, and that you tried but every attempt to contact Person B was unsuccessful. Accordingly, the panel found this charge proved.

Charge 5)a):

5) Did not escalate/adequately escalate the fact that you had not been in contact with Patient A since approximately 31 March 2017
   a) To your line manager

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1, the Caseload Management Session notes dated 16 May 2017 and your evidence.

The panel had sight of Caseload Management Session notes dated 16 May 2017. You attended the caseload management meeting with Ms 1, your line manager. The following notes were entered in relation to Patient A:

> *'Admitted to PICU via Police in Jan due to stripping off in a pub and hugging people. Stabilised quickly. [PRIVATE] Del is having difficulty catching him on time for his depot so it is often a few days late. [PRIVATE] No further CTO. Very polite. Gets on ok with Del. Does not want anything else from services.'*

In the weighting matrix ‘SS’ was recorded. This means that you reported that Patient A was in a stable condition and that it was a simple case.

In your evidence you told the panel that in these meetings with Ms 1, you could see her computer screen and what was being typed. You also confirmed that after this meeting you were sent a final draft of the Caseload Management session notes, giving you the opportunity to amend if necessary. By not challenging them you accepted that they were an accurate reflection of your discussion about Patient A.

The panel was of the view that you misled Ms 1 as you did not make it clear to her that you had not been in contact with Patient A since 31 March 2017. There was no other evidence to demonstrate that you had escalated that you had been unable to contact Patient A since 31 March 2017. The panel therefore concluded that you did not adequately escalate to Ms 1 that you had not been in contact with Patient A since 31 March 2017, [PRIVATE]. Accordingly, the panel found this charge proved.

Charge 5)b):

5) Did not escalate/adequately escalate the fact that you had not been in contact with Patient A since approximately 31 March 2017

b) To Patient A’s consultant psychiatrist

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 3 (Patient A’s consultant psychiatrist), the SWIFT record dated 2 June 2017 and your evidence.

The panel had regard to the SWIFT record dated 2 June 2017 in which you noted the following:

'Discussed [Patient A] with [Dr 3]. To continue to attempt to contact and to leave notes. If no response in 1 month to refer to Assertive outreach team under the Difficult to Engage Heading.'

In his evidence, Dr 3 told the panel that you had not spoken to him about Patient A until the conversation on 2 June 2017. The panel noted your evidence that you sent emails to Dr 3 and your SWIFT entry on 5 May 2017 stating that you had *'informed Dr 3'*. The Board had been unable to locate any such emails which would support your assertions. Dr 3 also told the panel that you did not make him aware that you had been unable to make contact with Patient A since 31 March 2017.

Dr 3 recognised that he should have seen Patient A at an out patients clinic four weeks after discharge from hospital (late April/early May) but did not recall seeing him. He said it was the CC's responsibility to attend with the patient and to follow up non-attendance. You said you were not aware of this appointment.

You told the panel that you did make Dr 3 aware that you had been unable to contact Patient A.

In the absence of any notes to support your evidence, the panel preferred the evidence of Dr 3. The panel accepted his evidence that if he had been aware of your lack of contact with Patient A, he would have sought to secure his attendance at hospital for assessment.

Accordingly, the panel found this charge proved.

Charge 6)

6) Your actions in any/all of charges 1,2,3,4 and 5 contributed to the death of Person B

This charge is found proved.

Before considering this charge the panel first determined the interpretation of *'contributed'* to adopt. The panel was of the view that *'contribution'* means that it was not the sole reason for the death of Person B, but, taken together with other factors, it was an element which played a part in the events leading up to the death of Person B.

In reaching this decision, the panel took account of its findings on each of the charges and considered each charge individually.

In respect of charge 1, the panel determined that your actions in administering the [PRIVATE] Depot to Patient A on 31 March 2017 when it was not due until 13 April 2017 were not relevant to the issues raised by charge 6.

The panel next considered whether your omissions in failing to administer the [PRIVATE] depot to Patient A on the dates listed contributed to the death of Person B. The panel noted that Patient A had only received one [PRIVATE] depot 100mg *'test dose'* on 22 March 2017 when he was in hospital and another [PRIVATE] depot 200mg on 29 March 2017 before he was discharged from hospital. The panel considered that there was enough evidence before it to safely conclude that this medication, if given as prescribed, is likely to have prevented or reduced the likelihood of [PRIVATE] that led to the death of Patient B.

With regard to charges 3 and 5, the panel concluded that your actions in not adequately escalating that Patient A had not received any of his [PRIVATE] depot from 13 April 2017 to 12 June, or escalating that you had been unable to contact him since 31 March 2017 contributed to the death of Person B. The panel heard evidence from Dr 3 that had he known you had not been in contact with Patient A since 31 March 2017, and that he was not receiving his prescribed treatment, he would have sought to secure Patient A's attendance at hospital for further assessment. [PRIVATE] The panel was of the view that, although you were Patient A's CC, your failure to have any contact with him over a

period of 12 weeks, and your failure to adequately escalate your lack of contact with Patient A, meant that a further assessment could not be carried out and the appropriate care could not be given. The panel noted there were only two documented attempts at contact following the failed depot administration on 13 April 2017.

The panel was of the view that your failure to contact Patient A, as set out in charge 4a, closed off any opportunity to assess Patient A's condition in the 12 weeks following his discharge from hospital.

The panel was of the view that your failure to contact Person B, as set out at charge 4b, did not contribute to the death of Person B. Person B was not clinically trained and therefore should not have been relied upon to raise concerns about Patient A to medical professionals. It was your responsibility to provide care to Patient A and to provide support to Patient A's family.

In respect of charges 2, 3, 4a and 5 the panel found this charge proved.

Submission on misconduct and impairment

Having announced its finding on 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.

The panel had regard to the submissions made by Ms Guest, on behalf of the NMC and Mr Snow on your behalf.

In her submissions Ms Guest invited the panel to take the view that your actions amount to breaches of '*The Code: Standards of conduct, performance and ethics for nurses and*

midwives 2015' (the Code). She then invited the panel to consider specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Ms Guest submitted that you failed to administer a prescribed, fortnightly depot injection to Patient A, over a period of 10 weeks. She submitted that your failures were fundamental, serious and contributed to the death of Person B. Ms Guest submitted that your actions fell far short of what is expected of a registered nurse and amounted to serious misconduct.

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 Guest submitted that the public interest is engaged in this case, and an informed member of the public would be concerned if a finding of no impairment were to be made in the circumstances. Ms Guest invited the panel to find that your fitness to practise is impaired on public protection and public interest grounds.

Mr Snow submitted that you have accepted your failings and are deeply sorry for your part in the incident of 12 June 2017. In respect of the events that took place on 12 June 2017, Mr Snow submitted that there are inconsistencies between the evidence of Ms 1 and Dr 3 about the decision not to send assistance in response to Person B's telephone call. Mr Snow submitted that you would have immediately gone to assist Person B if you had been contacted.

Mr Snow told the panel that you have retired from the nursing profession and that you have no intention of returning to nursing. Your NMC PIN and registration only remain active as a result of these proceedings. Mr Snow submitted that you have demonstrated sorrow and regret for your failings and the impact of these failings on Person B and her family. He submitted that your engagement with these proceedings, even though you

have retired, demonstrates your respect for the profession, and your empathy with and respect for Person B's family.

Mr Snow accepted on your behalf that your failings amount to serious misconduct.

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 GMC (No. 2) [2000] 1 AC 311, Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) and Cohen v General Medical Council [2008] EWHC 581 (Admin).*

The panel adopted a two-stage process in its consideration, as advised. Firstly, the panel determined whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amounted to misconduct, could the panel 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 breaches of the Code, specifically:

1.2 make sure you deliver the fundamentals of care effectively

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

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

20 Uphold the reputation of your profession at all times

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 charges 2, 3, 4, 5 and 6 individually and cumulatively, amounted to serious misconduct.

The panel was of the view that your continued failure to administer the [PRIVATE] Depot every two weeks as prescribed, over a period of 10 weeks, was very serious. Every day Patient A missed his Depot injection the risk to him and the public increased. The panel therefore considered that your failure to administer the [PRIVATE] Depot, as prescribed, did amount to serious misconduct.

Having failed to administer the [PRIVATE] Depot to Patient A and knowing the risks that this posed, the panel considered that your failure to escalate to Ms 1 or Dr 3 amounted to serious misconduct. Had you escalated the fact that Patient A had not received any of the prescribed [PRIVATE], a course of action could have been taken by Ms 1 or Dr 3 that might have averted the death of Person B. The panel acknowledged that at that time, there appeared to be a working culture in your team where there was a lack of proactivity in the MDT. However, the panel was mindful that every registrant is accountable for their own practice and that you had a professional responsibility to adequately escalate that Patient A had not received his required medication.

The panel was of the view that any efforts you made to contact Patient A were wholly inadequate. You were unable to give any credible explanation for this failure. The panel considered that your continued failure to contact Patient A and Person B after the unsuccessful visits also amounted to serious misconduct. You were under a duty to provide care to Patient A and to work closely with relatives to ensure this care was given. *'The Procedure for the Management of Service Users who disengage from their Care and Treatment Planning Programme of Care'* (Board policy – February 2017) placed the responsibility for escalating on you as Care Coordinator.

The panel determined that your failures which contributed to the death of Person B were deplorable and amounted to serious 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. 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, in reaching its decision, the panel considered the judgement of Mrs Justice Cox in the case of *Grant*. At 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 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. ...'

The panel finds that limbs a, b and c are engaged in this case.

The panel concluded that you have in the past acted so as to put patients and the public at unwarranted risk of harm. You did not administer medication as prescribed to Patient A and failed to adequately escalate this. Your actions and omissions placed Patient A at significant risk of harm and contributed to the death of Person B.

The panel determined that your failings breached basic and fundamental tenets of nursing practice including medication administration and completing tasks that were delegated to you. The panel determined that your misconduct is liable to bring the nursing profession into disrepute.

The panel then considered whether there is a continuing risk to patient safety. In doing so, the panel had regard to the issues of insight, remorse and remediation. For the

reasons set out below the panel has concluded that you are liable in the future to put patients at unwarranted risk of harm.

The panel was mindful that the issue it had to determine was that of current impairment. It therefore had to consider the risk of repetition. Any decision about the risk of repetition in this case would be informed by consideration of the level of insight you have demonstrated and by whether your misconduct is capable of being remedied and, if so, whether your misconduct has been remedied. In considering the risk of repetition, the panel was also mindful that there are elements of this case which appear to replicate the failures in your practice in 2015.

In relation to insight, the panel was of the view that you have not provided any evidence of reflection nor a rationale for your actions or an explanation for your misconduct. While you have expressed remorse for your actions, you failed to demonstrate any recognition of the wider impact of your shortcomings. The panel therefore determined that you have not yet demonstrated any meaningful insight.

While the panel is of the view that the misconduct found is potentially remediable, the starting point for any such remediation has to be an acknowledgement of, reflection upon, and insight into the deficiencies in question. The panel considered that there was no evidence of any steps you have taken to remedy the concerns raised about your fitness to practise. The panel noted that you have indicated that you have retired and do not wish to return to practice as a nurse. As you have not demonstrated that you have remediated your misconduct, the panel was of the view that the public would remain at risk of harm if you were able to practise without restriction. The panel finds that your fitness to practise is impaired on the ground of public protection.

The panel went on to consider whether the need to uphold proper professional standards and maintain public confidence in the profession would be undermined and the reputation of the profession brought into disrepute if a finding of impairment of fitness to practise were not made in the circumstances of this case. The panel

considered that if a member of the public were made aware of all the circumstances in your case, they would expect a finding of impairment on public interest grounds. The panel therefore concluded that a finding of impairment was necessary in the public interest.

The panel determined that your fitness to practise is currently impaired by reason of your misconduct both on the grounds of public protection and public interest.

Application to admit written statement pursuant to Rule 24(13) of the Rules

Before hearing submissions on sanction, a written statement from the family of Patient A and Person B was handed up to the panel. It heard submissions on the admissibility of this statement.

Ms Guest reminded the panel of the scope of these proceedings and how this hearing is to focus solely on the charges against you. She drew the panel's attention to Rule 24(13) of the Rules and submitted that it is open to the panel, at the sanction stage, to invite written submissions from any party who has an interest in these proceedings. Other than the reference to meeting with you, Ms Guest submitted that the concerns raised by the family about the organisational failings, strictly speaking, are not relevant to your case. She submitted that what weight to attach to this written statement is ultimately a matter for the panel.

Mr Snow submitted that the only relevant information in the written statement is the reference to your meeting with the family.

The panel accepted the advice of the legal assessor.

The panel had particular regard to the following part of the family's statement:

‘We all know what Delroy's failings and mistakes are and he has to live with this forever as us family and friends have to.

Myself and [PRIVATE] had a meeting with Delroy on Thursday as the day ended earlier than expected. This has helped us as a family as he Spoke[sic] with so much remorse and answered all our questions and more.’

The panel considered that it was to your credit that you met with the family in these difficult circumstances.

The panel also noted the family’s concerns about there being wider organisational issues and the restricted scope of the Board’s internal investigation into the events leading up to the incident of 12 June 2017. The panel considered that these concerns were in accord with its views as recorded in its assessment of witnesses and determinations on facts and misconduct and impairment. The panel was mindful of its obligation only to have regard to such aspects of this statement as were relevant to its deliberations at this stage of the hearing.

Determination on sanction

The panel heard submissions from Ms Guest, on behalf of the NMC and from Mr Snow on your behalf. The NMC sanction bid was for a striking off order. Mr Snow invited the panel to consider imposing a suspension order to allow you the opportunity to develop your insight and potentially return to nursing practice. He told the panel that after meeting with the family, you now felt motivated to return to practice.

The panel has considered this case very carefully and decided to make a striking off order. 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 has had regard to all the evidence that has been adduced in this case. The panel accepted the advice of the legal assessor.

The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the 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 identified the following aggravating and mitigating factors:

Aggravating:

- Repetition of failings identified by your line manager in 2015;
- Significant, repeated and fundamental failures;
- Your misconduct caused harm to Patient A and contributed to the death of Person B;
- Your misconduct had the potential to seriously damage the reputation of the profession;
- You concealed the fact that you had failed to administer the [PRIVATE] Depot or to have any contact with Patient A after 31 March 2017;
- Your lack of insight or explanation for your failings and your conduct, together with lack of remediation and the consequent risk of repetition;
- Your actions and omissions were careless in failing to escalate the increasing risk to Patient A and the risk he posed to Person B and the public.

Mitigating:

- You have met with the family of Patient A and Person B and apologised for your actions and demonstrated remorse to them;
- You admitted some of the charges against you at an early stage;
- At the relevant time, you were experiencing ill health;
- Organisational factors which may have led to a lack of scrutiny, ownership and oversight.

The panel first considered whether to take no action. The panel bore in mind that it had identified at the impairment stage that there remained a risk of repetition due to your lack of insight and lack of remediation. As such, any repetition of your misconduct would bring with it unwarranted risk of harm to patients. To take no action would therefore not provide protection to the public and would be inconsistent with the panel's findings at the impairment stage. In addition, the panel considered that to take no further action would be wholly inadequate given the seriousness of the misconduct found and would therefore fail in its aim to declare, uphold or maintain standards, and it would do nothing to maintain the public's confidence in the profession.

Next, in considering whether a caution order would be appropriate, 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 was clear that your impairment was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the misconduct found and also in view of the panel's finding on impairment. A caution order would offer no protection to the public, as it would not restrict your practice. Therefore, 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 relevant, proportionate, measurable and workable. With regard to public protection concerns, the panel noted that you are retired and had expressed no intention of returning to nursing. The panel therefore considered that a conditions of practice order is not workable in the circumstances. Further, at this stage, the panel determined that, in view of your lack of insight, a conditions of practice order could not be formulated to address the seriousness of the misconduct identified in this case, and would not sufficiently protect the public or recognise the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel took into account the SG, in particular:

> *'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 your misconduct did place patients at significant risk of harm. It bore in mind its findings that there is a high risk of the misconduct being repeated due to your lack of insight and remediation. This would place patients at unwarranted risk of harm. The panel determined that your misconduct was a significant departure from the standards expected of a registered nurse. The misconduct related to a patient who was particularly vulnerable. This was aggravated by the fact that there was a history of similar concerns in 2015; you sought to mislead other members of the team about the administration of Patient A's medication and your contact with him.

The panel therefore determined that these serious breaches of fundamental tenets of the profession are incompatible with you remaining on the register. The panel was again clear that a suspension order would not be a sufficient, appropriate or proportionate sanction to either protect the public or satisfy the public interest. In the panel's judgement, public confidence in the profession and the NMC as a regulator would be undermined by the imposition of a suspension order.

Finally, in considering a striking-off order, the panel took note of the following paragraphs of the SG:

> *'This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional, which may involve any of the following factors.*
>
> - *A serious departure from the relevant professional standards as set out in key standards, guidance and advice.*
> - *Doing harm to others or behaving in such a way that could foreseeably result in harm to others, particularly patients or other people the nurse or midwife comes into contact with in a professional capacity. Harm is relevant to this question whether it was caused deliberately, recklessly, negligently or through incompetence, particularly where there is a continuing risk to patients. Harm may include physical, emotional and financial harm. The seriousness of the harm should always be considered.*
> - *...*
> - *…*
> - *…*
> - *…*
> - *Persistent lack of insight into seriousness of actions or consequences…'*

The panel determined that your conduct in respect of the charges found proved were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that significant failings, particularly in respect of your failure to care for Patient A and your failure to escalate that he had not received his prescribed medication, disregarding the associated risks this posed, makes it incompatible for you to remain on the register. Furthermore, you sought to conceal your actions and omissions. Your lack of any significant insight into or explanation for your behaviour was also a factor that the panel considered. Your misconduct was so serious that to allow you to continue

practising as a nurse would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all of the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. It is the only order sufficient to protect the public and meet the public interest in declaring and upholding the proper standards in the nursing profession and to meet the public interest in maintaining public confidence in the nursing profession and the NMC as its regulator.

Accordingly, the panel directs that your name be removed from the Register.

Determination on Interim Order

The panel has considered the submissions made by Ms Guest that an interim order should be made on the grounds that it is necessary to protect the public and that it is in the public interest and to do otherwise, would be inconsistent with its determination.

Mr Snow did not oppose this application.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary in the public interest and to protect patients. 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.