Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 27 March – Thursday 6 April 2023

Tuesday 22 August – Friday 25 August 2023

Virtual Hearing

Name of registrant:	**Corie Hoelters**
NMC PIN:	09H0020O
Part(s) of the register:	Registered Nurse Sub Part 1 - 13 August 2009
Relevant Location:	Brighton
Type of case:	Misconduct
Panel members:	Adrian Blomefield (Chair, Lay member) Sandra Lamb (Registrant member) Melanie Swinnerton (Lay member)
Legal Assessor:	Paul Hester
Hearings Coordinator:	Monsur Ali (27 March 2023- 5 April 2023) Nandita Khan Nitol (5-6 April 2023) Anya Sharma (22 August 2023) Sharmilla Nanan
Nursing and Midwifery Council:	Represented by Tom Hoskins, Case Presenter
Mrs Hoelters:	Present and represented by Jim Olphert, of Counsel
No case to answer:	Charges 2 and 3
Facts proved:	Charges 1, 4a and 4c
Facts not proved:	Charges 4b and 5
Fitness to practise:	Impaired

Sanction:	**Conditions of practice order (3 years)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge (as amended)

That you, a registered nurse:

1. On 15 June 2017 failed to administer and/or ensure that Patient A was administered the correct dosage of morphine.

2. On or around 15 June 2017, failed to make an accurate record regarding the morphine dosage administered to Patient A on the datix.

3. Your actions at 2 above were dishonest in that you sought to conceal the extent of the mistake that you had made with the morphine.

4. On 11 April 2020:
   a) Failed to administer and/or ensure that Patient B was administered the correct dosage of morphine;
   b) Failed to report to colleagues the correct dosage of morphine that had been administered to Patient B;
   c) Failed to make an accurate record regarding the morphine dosage prescribed to Patient B on the datix.

5. Your actions at 4c above were dishonest in that you sought to conceal the extent of the mistake that you had made with the morphine.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Hoskins, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of Charge 5.

The proposed amendment was to delete the words *'and/or 4d'* in Charge 5 as there is no Charge 4d within the schedule of charges.

The panel of its own volition proposed to insert the word *'on'* at the beginning of charge 1.

Mr Olphert, on your behalf, stated that he did not object to the NMC's application nor the panel's proposed amendment.

The panel heard and accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel decided that as there is no Charge 4d within the schedule of charges to delete the words *'and/or 4d'* within Charge 5. Further, as there was no objection from either party the panel decided to insert the word *'on'* in Charge 1. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed.

The amended charges are as follows:

That you, a registered nurse:

1. **On** 15 June 2017 failed to administer and/or ensure that Patient A was administered the correct dosage of morphine.

5. Your actions at 4c ~~and/or 4d~~ above were dishonest in that you sought to conceal the extent of the mistake that you had made with the morphine.

Decision and reasons on application for hearing to be held in private

Mr Olphert made an application that parts of this case be held in private on the basis that proper exploration of your case [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

Mr Hoskins supported the application to the extent that [PRIVATE] should be heard in private.

The legal assessor advised 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 that where circumstances relating [PRIVATE] matters are raised, those parts will be held in private to preserve your privacy.

Further evidence

By agreement, between the parties, the panel received further documents from the NMC. The documents were copies of a prescription, medical progress notes and a controlled drugs book entry all relating to Patient B. Having placed the documents before the panel, both counsel made comments and observations upon those documents. Neither party submitted that they wished to recall Witness 4 or any other witness in light of this further evidence.

The panel heard and accepted the advice of the legal assessor.

The panel noted that the further evidence is not produced by way of a signed witness statement. However, the panel noted that it can receive evidence by agreement of both parties. Accordingly, the panel decided to receive this further evidence by way of agreement.

The panel considered the further evidence carefully and in light of all of the evidence that it has heard and read to date. It considered whether to recall Witness 4 or any other witness. The panel decided that it would not recall any witness at this stage. However, it will keep the matter under review and may recall any witness if necessary. In making this decision, the panel also noted that Mr Hoskins is at liberty to recall any witness having heard your evidence.

Decision and reasons on application of no case to answer

At the close of the NMC's case, after the panel had heard live evidence from four witnesses, the panel considered an application from Mr Olphert that there is no case to answer in respect to the Charges 2 and 3. This application was made under Rule 24(7) of the Rules. Mr Olphert submitted that Charge 2 is not evidentially made out and if this charge falls away then Charge 3 will organically fall away. However, even if the panel is to conclude that there was evidentially a basis for Charge 2, he submitted that there is no basis for Charge 3.

Mr Olphert referred the panel to the case of *R v Galbraith* [1981] 1 WLR 1039 and submitted that this case sets out two limbs. The first is that there is no evidence to support a charge and second is that there is some evidence, however, it is so tenuous that a panel properly directed by the law could not find the matter ultimately proved. Mr Olphert submitted that the evidence the NMC produced, in particular the 2017 Datix, in relation to Charge 2 is extremely limited. Mr Olphert contrasted this with the evidence given by Witness 4 in relation to the 2020 Datix where Witness 4 agreed that there are entries on the Datix which showed progression or development to the document in question.

Mr Olphert further submitted that the source material in relation to Charge 2, the Datix, appears to disclose no basis that there was under reporting of the morphine dosage or that there was an error of reporting. The only document which appears to suggest a specific difference of reporting is contained in the *'Minutes of meeting'.* He submitted that there is an absence of any rationale for the conclusion statement within those minutes which showed that the overdose was initially reported as times ten but it is actually times 100 dose. He submitted that it is clear that at best the *'Minutes of meeting*' is a comment reached at the risk meeting and is simply not reflected in the evidence before the panel. He submitted that this document is at best hearsay and that the panel should ascribe little or no weight to it.

Mr Olphert also submitted that there was confusion in the intravenous (IV) training update documents and safety newsletter (Baby Watch newsletter) referred to in evidence as to the extent of the dose administered. He submitted that Charge 2 falls away under limb one of *Galbraith* as the documents are mere comments and opinions which are incapable of being admissible evidence. Mr Olphert further submitted that if the panel does accept any of the evidence as credible or reliable then that evidence is so tenuous or inconsistent that it simply cannot support this charge.

Mr Olphert submitted that if the panel does determine that there is sufficient evidence in relation to Charge 2, there is no evidence before the panel that supports Charge 3. He submitted that there is simply no evidence to suggest dishonesty on your part in relation to this charge as there is no indication that anything misleading was said by you which is consistent with an allegation of dishonesty.

Mr Olphert submitted that there is no evidence that suggests there was misreporting of the dose and certainly there is no evidence that demonstrates you knew or believed it had been misreported. He therefore submitted that there is no evidence to suggest that you tried to mislead anybody and invited the panel to find no case to answer in relation to Charges 2 and 3.

Mr Hoskins submitted that the *'Minutes of meeting'* are not mere comments or opinions, rather they are statements of fact and that there was an overdose. He submitted that, to suggest that this is not evidence because it states that the actual dose was 100 times rather than ten times, is not correct.

Mr Hoskins submitted that the issue with credibility and reliability should be left for the facts stage and not be considered at this stage.

Mr Hoskins submitted that it is not disputed that an error had occurred. However, your later reaction emerged from the 2020 investigation about what had happened in 2017 is important evidence, which directly goes to your credibility. He reminded the panel that Witness 3 stated that you went into the room with him and a consultant and that you made a reference to an earlier error. He invited the panel to carefully compare and contrast your initial reactions to the two separate incidents in 2017 and 2020. He submitted that there was a significant similarity in that you stated in relation to both incidents that your recollection was poor and that this should go to the question of your credibility.

Mr Hoskins submitted that the *'Minutes of meeting'* are not opinion because the panel is aware of some of the circumstances in which this document was produced. He submitted the panel has sufficient information within the document to find it credible as it was generated in a very important meeting which was attended by senior people from the Trust.

Mr Hoskins submitted that there was a Baby Watch newsletter, something circulated widely, which indicated that it was a 100 times dose. However, he conceded that the strength of that claim is mitigated by the IV training update which indicated ten times the dose. Nevertheless, he submitted that the Baby Watch newsletter would not have gone out stating that 100 times the dose had been administered if this was not correct.

Mr Hoskins referred the panel to your witness statement where you state that it was ten times the dose. However, you state that there was issue of dilution of vials, and he submitted that if that was the problem then the error would be 100 times the dose.

Mr Hoskins submitted that in light of all the documents and the live witness evidence, there is sufficient evidence to suggest, as was found in that risk meeting, that the overdose was 100 times rather than ten times.

Mr Hoskins submitted that the issue of dishonesty remains. In relation to dishonesty, he submitted that the evidence is circumstantial but the fact that it is circumstantial does not necessarily mean that it is insufficient when applying the test in *Galbraith*. He invited the panel to take into account the circumstantial matters, the senior Band 6 role held by you at this point, the fact of an error occurring, the inconsistencies in accounts given, namely what is in the Datix and what had been said to Witness 3 and the other consultant about immediately being aware of it in 2020, the denial of the previous incident in the serious incident report, and providing detail that contradicts the Datix report.

Mr Hoskins submitted that given that the issues of credibility are typically left for the next stage of the proceedings, there should be no difference in this case.

The panel took account of the submissions from both parties and accepted the advice of the legal assessor.

In reaching its decision, the panel carefully assessed the relevant evidence in relation to this application. In making its assessment, the panel had regard to the '*Minutes of meeting',* the Datix and the evidence of Witness 4.

The panel considered whether there is any evidence upon which a properly directed panel could find the alleged facts proved.

The panel firstly considered whether there is a case to answer in respect of Charge 2.

The panel carefully considered the provenance of the '*Minutes of meeting'*. It noted that it could not establish the date of the Minutes, who was present, what documentation they considered and whether any members of staff were interviewed. The '*Minutes of meeting'* are isolated and not referrable to any other minutes in relation to this incident. Further, it is not signed and therefore attributable to any investigator. The panel further noted that the '*Minutes of meeting'* are unspecific and refer to a generic 'nurse'. The panel was provided with no evidence that the 'nurse' was you.

The panel carefully considered the evidence of Witness 4 in relation to '*Minutes of meeting'*. Witness 4 was asked questions as to the provenance of the document but was unable to shed any light on the factors above. In particular, the panel noted that Witness 4 was unable to say where the *'x 100 dose'* came from.

In light of the lack of provenance the panel decided that it could not place any weight on the '*Minutes of meeting'*. Accordingly, as no weight was ascribed to this document the panel decided that the '*Minutes of meeting'* falls under limb one of *Galbraith*.

The panel carefully considered the Datix. It noted that this appears to have been completed by you and the dates within the Datix do relate to the date of the incident. However, the panel heard evidence that others had access to the Datix subsequent to you writing your entry. In considering the Datix the panel could not establish whether the Datix was in fact altered, if so, what was altered and when. The panel therefore decided that whilst the Datix provides some evidence, it is not supported by any other credible sources such as a prescription chart, a drug administration record and contemporaneous medical notes. In these circumstances, the panel decided that the Datix is evidentially inherently weak and therefore tenuous.

The panel noted that within the Datix there is nothing beyond '*x 10*' and the subsequent IV training update circulated to the staff mentions times ten. Further, the panel noted that it

was not provided with the Baby Watch newsletter and therefore was not provided with the evidence of the multiple of the overdose quoted in it.

The panel carefully considered the evidence of Witness 4 in relation to the Datix and noted that she was unable to shed any light on the document beyond the document itself.

The panel had regard to the wording of Charge 2 in that it alleges a failure to make an '*accurate'* record. In considering the evidence the panel could find nothing within the Datix to support the contention that any entry was inaccurate.

In light of the above reasons the panel decided, in relation to Charge 2, that the evidence is tenuous and that there is no case to answer.

The panel noted that Charge 3 is conditional upon a finding in relation to Charge 2. As there is no case to answer in relation to Charge 2 it follows that there is no case to answer in relation to Charge 3.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Olphert, who informed the panel that you made full admissions to charges 1, 4a and 4c.

The panel therefore finds charges 1, 4a and 4c proved in their entirety, by way of your admissions. Whilst charge 1 does not specify any quantum as to the incorrect dosage administered the parties invited the panel to make a finding of fact as to whether the overdose in 2017 was, on the NMC's account 100 times, or, whether it was 10 times in accordance with your case.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Hoskins on and those made by Mr Olphert.

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 a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Formerly Staff Nurse on the Trevor Mann Baby Unit at University Hospital Sussex NHS Foundation Trust
- Witness 2: Neonatal Senior Sister on the Trevor Mann Baby Unit at University Hospital Sussex NHS Foundation Trust
- Witness 3: Consultant Neonatologist at University Hospital Sussex NHS Foundation Trust
- Witness 4: Divisional Director of Nursing for Children and Gynaecology at University Hospital Sussex NHS Foundation Trust

The panel heard evidence from you under affirmation.

The panel also heard live evidence from the following witness called on your behalf:

- Witness 5: Senior Consultant at University Hospital Sussex NHS Foundation Trust

The panel also read agreed evidence from:

- Witness 6 Neonatal Technical Specialist
- Witness 7 Operational Service Manager
- Witness 8 Registered Mental Health Nurse

Background

Charges 1, 2 and 3 arose whilst you were employed as a Band 6 senior staff nurse at University Hospital Sussex NHS Foundation Trust (the Trust) previously named as Brighton and Sussex University Hospital NHS Trust.

Charges 4 and 5 arose whilst you were employed as a Band 7 senior sister in the neonatal intensive care unit at the Trust.

It is alleged that you were involved in a drug error as second checker whereby a neonate was given x 1000 overdose of morphine. Patient B, a 2-day old baby weighing 1.315kg was administered a bolus dose of morphine which was prescribed at 25mcg/kg. It is alleged that you administered a dose of 32.88 mg as opposed to the prescribed dosage of 32.88mcg, resulting in the Patient B receiving 1000 times the required dose.

Patient B was given emergency treatment and care. Patient B was thereafter ventilated and stabilised.

It is further alleged that there was a similar error involving you and an overdose of morphine to a neonate, in 2017.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and you.

The panel then considered each of the remaining charges and made the following findings of fact.

Charge 1

> On 15 June 2017 failed to administer and/or ensure that Patient A was administered the correct dosage of morphine.

This charge has been found proved by way of your admission.

Whilst this charge has been admitted by you the parties invited the panel to make a decision as to the scale of the overdose administered to Patient A. The NMC submitted that the overdose was 100 times whereas your case is that the overdose was 10 times.

In reaching this decision, the panel took into account the Datix, the *'Minutes of meeting'*, witness evidence from Witness 5 and from you, references within the Baby Watch newsletter and IV training update.

The panel when deciding that there was no case to answer in respect of charge 2 decided to attach no weight to the 'Minutes of meeting' in view of the lack of detail around dates

and the provenance of those minutes. The ‘Minutes of meeting’ recorded that the dose was 100 times but because the panel attached no weight to those notes, that is something the panel discounted.

The panel considered the evidence from Witness 5 who was the senior consultant present on the ward on the date the 2017 incident occurred who confirmed both in her witness statement and in her oral evidence that she was under the impression on 15 June 2017 that the dosage administered had been 10 times the prescribed amount. The Witness said in her evidence that it remained her view that the overdose was 10 times the prescribed dosage until she was first made aware of the undated ‘Minutes of meeting*’* referred to in the above paragraph when the dosage was apparently referred to as the 100 times.

The panel had regard to your evidence which was consistent in that you maintained that it was a 10 times overdose.

The panel had regard to the Baby Watch newsletter and were told by Witness 4, to the best of her recollection, that the newsletter contained material indicating a morphine overdose of 100 times. However, the panel did not have sight of the Baby Watch newsletter and there is no direct evidence to substantiate that there was a reference to 100 times beyond Witness 4’s recollection of a document which was produced within the Trust more than five years ago.

The panel also had regard to the IV training update which was referred to by Witness 4 in her witness statement as well as her oral evidence. Again, the panel did not have the sight of this document. The panel was told that the IV training was apparently delivered after the 2017 incident but was provided no direct evidence to show that the training was referrable to 2017 incident.

The panel did not hear from any direct witnesses from the 2017 incident who contradicted the evidence of Witness 5 and your evidence. It also did not receive any investigation

documents in relation to the incident, no copy of the controlled drug book and no copy of the prescription.

In light of the above, the panel determined that the NMC has not discharged its burden of proof on the balance of probabilities. Accordingly, the panel decided that the overdose was, on the balance of probabilities, 10 times the prescribed amount.

Charge 4b)

On 11 April 2020:

4b)Failed to report to colleagues the correct dosage of morphine that had been administered to Patient B;

This charge is found NOT proved.

The panel noted the wording of the charge 4b, which is drafted as a failure. For the NMC to prove a failure, it must prove that you did not report to colleagues the correct dosage of morphine that had been administered to Patient B; that there was a duty to do so; and that reporting had been to a given a standard.

The panel firstly considered whether you did report to colleagues the correct dosage of morphine that had been administered to Patient B. The panel considered each of the colleagues who attended Patient B during the incident.

The alarm was raised in relation to the condition of Patient B.

Dr 1, the Registrar, attended Patient B. The panel has received no evidence from Dr 1. However, there is evidence that Dr 1 was immediately made aware that there had been an overdose administered to Patient B. Dr 1 administered naloxone which is a medication used to reverse the effects of a morphine overdose.

The panel noted that Witness 2 was present at the outset of this incident and that she had a conversation with Witness 1 who acted as first checker when Patient B was administered the morphine. Witness 2 stated that Witness 1 told her that 0.3 mls of the 10 in 1 strength was administered. The panel noted that the evidence was clear at this stage that you were not present during this conversation between Witness 2 and Witness 1. During the conversation between Witness 2 and Witness 1 the panel heard evidence that you were not present as you were sourcing an alternative mask for Patient B whilst Dr 1 was in attendance.

The panel considered the fact that you were not in continual attendance of Patient B as being unusual as you were the Band 7 nurse in charge of the unit and consequently attending to other patients and staff. You left Patient B in the hands of Dr 1.

The panel noted that there was no evidence from Witness 1 as to the conversation between you and Dr 1 when Dr 1 initially arrived at the cot side of the Patient B. It appears that Witness 1 left you, Dr 1 and Witness 2 who had arrived to assist, as Witness 1 was upset. The panel is aware that other clinical staff were also present, including other nurses, at the cot side, but it had no direct evidence from them. The panel noted that you left the cot side to find an alternative mask for Patient B. When you returned Dr 1 was still with Patient B and you gave Dr 1 the alternative mask. At this stage, it appears that the naloxone was administered. The panel has no evidence from Dr 1 as to what you may have told her at the outset of the incident other than Witness 2 stating that naloxone was administered to Patient B almost immediately.

In these circumstances, there is no direct evidence from the NMC that you failed to report to Dr 1 about the correct dosage of morphine that had been administered to Patient B.

The panel noted that at this stage there was a clear entry in the controlled drugs (CD) book, signed by you, which shows the amount and strength of morphine which had been

taken from the morphine stock. The CD book is a record which was available for all clinicians to refer to during this incident.

The next colleague to attend Patient B was the consultant, Witness 3.

Witness 3 was interviewed by Witness 4 at an investigation meeting on 3 July 2020. During that meeting Witness 3 recalled that he attended Patient B, and that Dr 1 was present. He stated during the meeting that he was aware at the outset that there must have been a morphine overdose. Witness 3 asked how much morphine Patient B had been administered. The panel noted that at this stage you were not present, but Witness 1 was. Witness 3 was told that *'10 mg/ ml vial was opened and 0.3ml was administered'* which he calculated as being times 100 overdose. Thereafter, it appears from Witness 3 that Witness 2 raised the possibility that the overdose was times 1000. Again, you were not present during this conversation as between Witness 3 and Witness 2.

Patient B was intubated and stabilised. Later, that day at a time which is unclear Witness 3 stated during the meeting that '*I asked [you] again how much was administered, and I remember vaguely [you] said 328 which calculated 100 times the dose'*. Further into the meeting, Witness 3, was specifically asked by Witness 4 whether you had said 328 and whether Witness 3 did a calculation with you. The panel noted that Witness 3 replied '*I can't remember clearly but I think it was with one of the nurses*.' Given this response by Witness 3*,* Witness 4 asked whether *'there was a lack of clarity?*' Witness 3 replied '*Yes, there was a lack of clarity/ confusion with regards to how much morphine was actually administered*'.

From the above evidence, it appears that Witness 3, when pressed could not definitively say whether it was you or another nurse who told him that the dose administered was 328. In these circumstances, the panel could not attribute you telling Witness 3 that the overdose was times 100 the prescribed dose.

Witness 3 was further interviewed by Witness 4 at an investigation meeting on 1 October 2020.

At the outset of the investigation meeting, Witness 4 asked '*what did [you] report to [*Witness 3] *as the error in the first instance?*' Witness 3 replied that there was a lot of confusion regarding the dosage and that he could vividly remember you being in and out of the room. Witness 3 stated that Dr 1 was present when he attended Patient B but that you were not there. Witness 3 stated that naloxone was administered, and he went on to say that, at this stage he prioritised Patient B and that Witness 2 said to him that '*may be 1000x*' had been administered.

Witness 3 told at the investigation meeting that he stabilised Patient B. He also said that he had spoken to 'Toxbase', a toxicology advice service, and Patient B's parents in respect of a 1000 times overdose.

Witness 3 was asked by Witness 4 at the investigation meeting, '*Do you remember someone saying 3.3 mls because there has never been any clarity on the volume before when I have spoken to you- do you remember who said 3.3 mls?*' Witness 3 replied '*Yes I remember someone saying it but I can't remember who*'.

Witness 3 could recall, during the investigation meeting, that he had a conversation with you and Dr 2, at Dr 2's office. The panel had no direct evidence from Dr 2. Witness 3 stated that during this conversation he did not discuss the dose with you. Witness 3 did say that he could not attribute to you that you had said to him 0.3mls. in reply to a specific question from Witness 4, Witness 3 said '*it's all confusion I can't remember*'.

The panel carefully considered Witness 3's oral evidence. Having heard his oral evidence, the panel noted that his recollection was tenuous and reflected his somewhat vague accounts given during the two investigation meetings. The panel noted that Witness 3 during his oral evidence stated that he was '*very confused*' and that with the passage of time he was '*even vaguer now*'. The panel noted that it was clear from Witness 3's

evidence that his focus and concentration during the incident was on treating Patient B and that he may not have been in the best position thereafter to recollect exactly what happened and what was said at the time. The panel noted during Witness 3's oral evidence that correctly he was unwilling to speculate as to what may have been said and to speculate as to who exactly said what.

Having considered Witness 3's evidence, the panel noted that he was unable to specifically recall whether you had failed to report to him the correct dosage of morphine that had been administered to Patient B. Further, the panel decided that it could not safely attribute any dosage told to Witness 3 by any specific clinician who attended Patient B.

The panel noted that Witness 2 claims that there was a conversation at some stage between you and Witness 2 which you denied having ever taking place. Witness 2 said that she told you that Witness 1 had confirmed 0.3mls of the 10mg in 1ml Morphine had been given. Witness 2 stated that you did not respond to this assertion to either agree or disagree, but you nodded and said '*uhhuh*'. Witness 2 interpreted this as being agreement to the assertion. The panel carefully considered this evidence but decided that, if this conversation had taken place as Witness 2 claims, it could not safely interpret your response as either agreement or disagreement.

The panel carefully considered your evidence. It noted that you were consistent in your written reflection, account of drug overdose, responses during the investigation meeting on 29 June 2020. In your responses at the disciplinary meetings, your statement and oral evidence you have always said that it was a times 1000 overdose and/or 3.3mls that was administered to Patient B.

In considering all of the above evidence the panel determined that the NMC has not discharged its burden of proof in respect of charge 4b.

The panel could find no clear evidence that you did not report to colleagues the correct dosage that had been administer to Patient B.

Accordingly, the Charge 4b, on the balance of probabilities not proved.

Charge 5) (As amended)

> 5)Your actions at 4c above were dishonest in that you sought to conceal the extent of the mistake that you had made with the morphine.
>
> AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

This charge is found NOT proved.

At the outset of this hearing, you admitted to charge 4c. The panel therefore went on to consider in respect of charge 5 whether your failure was an honest mistake, or a conscious misreporting of the dosage administered which sought to conceal the actual dosage administered.

The panel had regard to the test for dishonesty in *Ivey v Genting Casinos (UK) Limited t/a Crockfords* [2017] UKSC 67, [2018] 3 WLR 1212 SC (E). The panel noted that it must apply a two-stage process. Firstly, it must ascertain the actual state of your knowledge or belief as to the facts. The reasonableness or otherwise of your belief is a matter of evidence, often in practice determinative, going to whether you held the belief. It is not an additional requirement that your belief must be reasonable; the question is whether it was genuinely held. Secondly, the panel must ask itself whether your conduct was honest or dishonest by applying the standards of ordinary decent people. There is no requirement that you must appreciate what you have done is, by those standards, dishonest.

The panel carefully considered all of the above evidence so as to ascertain your actual state of mind as to knowledge or belief. The panel noted that you are an experienced nurse who was practicing as a Band 7 nurse on 11 April 2020. As an experienced nurse

you would have known of the Datix process and, in particular, the way in which a Datix would be subject to scrutiny after a significant overdose.

The panel noted that at the outset of this incident you were the second checker to Witness 1. It is apparent from Witness 1's evidence that early on in this incident she realised that an overdose had been administered which was times 1000. It appears that from Witness 1's investigation meeting on 14 July 2020 that she communicated the level of the overdose to Witness 2 during the subsequent treatment of Patient B.

Witness 3 attended Patient B and was informed that there had been an overdose administered. Witness 3 was told by Witness 2 of the overdose possibly being times 1000 at some point after Patient B was stabilised. This information appears to have been relayed to Witness 3 by Witness 2 by relying upon earlier conversation with Witness 1 and after Witness 2 had had sight of the CD book. Witness 3 having stabilised Patient B then told the parents of Patient B that the overdose was times 1000.

It appears that Witness 3 and you had a conversation after Patient B was stabilised concerning the completion of a Datix. Witness 3 could recall this conversation and that it was agreed that you would complete the Datix. Witness 1's evidence was that she heard this conversation but that you said that you had already completed the Datix. The panel carefully considered the differing accounts as between Witness 3 and Witness 1 of your conversation with Witness 3. Your account was consistent with Witness 3. The panel decided that Witness 3's account was, on the balance of probabilities, more likely to be correct. The panel noted that a number of a witnesses described Witness 1 as being very upset after the incident and that she was at times crying which may have affected her ability to accurately recall events.

The panel noted that the CD book was completed and signed by you at the outset of the incident and was clear as to the amount and strength of morphine taken from the Morphine stock. There was no attempt to hide or at any time change the record within the CD book.

The panel carefully considered the conversation that you had with Witness 3 in Dr 2's office when you said that '*I don't want people to judge me*'. You said this in acknowledging that an overdose had been administered to Patient B. The panel placed significant weight upon your words as you knew, as an experienced nurse, that the incident would be investigated. Further, during your conversation with Witness 3, it was agreed as between you that you would complete the Datix. At this stage, Witness 3 had information that the overdose was possibly times 1000 which he duly relayed to the parents of Patient B.

Following the discussion with Witness 3 you continued your duties as the nurse in charge of the unit. In completing your duties, it appears from the record of what you said in the investigation meeting that you had mentioned that you had a busy workload that shift which included admitting a patient into isolation. Consequently, you did not complete the Datix until 8:31pm, after the end of a difficult working day when you said you were in '*utter distress*', and an hour after your shift should have finished.

The panel gave careful consideration to the entries which you made in the Datix. The Datix required you to identify the level of harm, the dose administered and what should have been the correct dose.

The panel noted Mr Hoskin's submissions that you appeared to have downgraded the level of harm from moderate to low so as to intentionally conceal the extent of the mistake which had been made. Likewise, he submitted that you had deliberately misstated the level of the dose which you entered as 38.2 micrograms when it should have been 32.8 micrograms which was similar with the dose administered 382 micrograms instead of 328 micrograms.

The panel carefully considered Mr Hoskin's submissions in light of the attendant evidence. The evidence, in the panel's view, is clear that there was widespread knowledge of the incident and the possible overdose within the Unit and externally soon after the incident. Witness 1, Dr 1, Witness 2, and Witness 3 knew of the overdose and further that Witness

3 had spoken to ‘Toxbase’ and communicated to Patient B’s parents an overdose times 1000. There was clear evidence from the prescription and the CD book that shows that the overdose had occurred by a multiple of 1000. Patient B was manifestly unwell after the morphine administration and was treated with naloxone and intubated. Patient B’s condition and treatment were obvious evidence that this was a significant incident. Accordingly, it appears that the overdose and the possible level of that overdose was in the general domain and that you, from your evidence, knew this.

You were the nurse in charge of the Unit. As such most if not all the above factors would have been known to you when you filled in the Datix. As stated above you are an experienced nurse who has had experience of filling in Datix in the past in relation to other incidents involving others. In the panel’s professional view, you would have known that your Datix would be subject to close scrutiny in light of the clinical deterioration of Patient B and the attendance by a number of senior clinicians and subsequent escalation of treatment. In these circumstances, the panel decided that your entries would not have had the effect of concealing the extent of the mistake and you would, more likely than not, have known this.

The panel noted *Lavis v NMC* [2014] EWHC 4083 (Admin) which holds that there is a need of cogent evidence in order to make a finding of dishonesty and of the need to consider any other possible explanation for the conduct in question.

The panel carefully considered the background to you filling in the Datix.

It appears that you did focus upon Patient B, and you sought to assist Dr 1 and Witness 3 in the initial stages of seeking to stabilise Patient B. In the panel’s professional view, you had involved in a serious drug error which resulted in Patient B requiring emergency treatment. This had resulted in a stressful shift for the whole team. You were also the nurse in charge of the unit and had other managerial and clinical duties, including admitting a patient into the Covid isolation nursery. Further, the panel noted that this was

during the early stages of the first Covid lockdown which required the unit to significantly alter its procedures within the unit and in communicating with parents and families.

The panel noted from your oral evidence that you were exhausted when you completed the Datix. In your statement, you stated that at this stage that you were [PRIVATE]. Given, this background the panel decided that this is a plausible explanation for your mistakes in the Datix. The first mistake was a simple transposition error of the figures. Further, the downgrading of the incident appears to have been a mistake when selecting from a drop-down menu. The panel also noted in your evidence that you were frank that you did not pay sufficient attention when completing the Datix, but this was due to you being extremely tired and [PRIVATE].

The panel carefully considered your reflection on the morphine error, the account of drug error, and your responses at the investigation and the disciplinary meetings. On each occasion you accepted the error and that you had incorrectly completed the Datix. The panel noted that at no stage did you go behind the overdose of times 1000. In particular, the panel noted that your reflection was written on 13 April 2020 which was two days after the incident. The panel also noted that it appears that you took full responsibility for the overdose and from the evidence of Witness 1 that you apologised to her. The panel noted the character evidence from Witness 5, Witness 6, Witness 7 and Witness 8.

In light of all of the above circumstances, the panel decided that the NMC has not discharged its burden of proof in relation to charge 5. The panel determined that the evidence was not sufficiently cogent in order to make a finding of dishonesty and there was a credible explanation for the inaccuracies within the Datix.

Accordingly, charge 5 is not, on the balance of probabilities, found proved.

This case was adjourned part heard on 6 April 2023 and resumed on 22 August 2023.

Fitness to practise

Having reached its determination on the facts of this case, 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 also had regard to the NMC's guidance on impairment, reference DMA-1, dated 27 March 2023, states *"The question that will help decide whether a professional's fitness to practise is impaired is: "Can the nurse, midwife or nursing associate practise kindly, safely and professionally?" If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired."*

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Mr Hoskin's referred the panel to the case of *Roylance v General Medical Council (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.'*

Mr Hoskin's invited the panel to take the view that the facts found proved amount to misconduct. Mr Hoskin's referred the panel to 'The Code: Professional standards of

practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific, relevant standards where your actions amounted to misconduct. He submitted that you did not prioritise the safety of the babies in your care and as a consequence you [PRIVATE]. He acknowledged the level of insight you have demonstrated in relation to these incidents. He referred the panel to the witness evidence which suggests the seriousness that underpins the charges.

Mr Olphert submitted that it was your own admission that your conduct fell below the standards expected of you and below the NMC Code of Conduct. He submitted that it is for the panel's consideration whether your conduct is a serious falling short such that the very high bar for professional misconduct is made out. He reminded the panel of your oral evidence, as to your action plan to address the concerns with IV drug administration to prevent incidents of a similar nature occurring again. He also referred the panel to your reflective accounts conveyed your apologies to the parents affected. He referred the panel to the judgement in *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and addressed the panel on each charge found proved and if it amounted to serious professional misconduct in the circumstances.

Submissions on impairment

Mr Hoskin's moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and satisfying 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. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Hoskin's submitted that your misconduct involved basic drug administration and record keeping which nevertheless led to patient harm and therefore serious misconduct. In these

circumstances, he submitted that the extent of your misconduct brought the nursing profession into disrepute and breached the fundamental tenets of the profession.

Mr Olphert submitted that the panel will need to consider impairment under the broad headings of risk to public safety and the wider public interest. He noted that the panel will consider under the heading of risk to public safety, your insight, remorse and remediation. He submitted it is essential that the panel considers the risk of your conduct being repeated. He submitted that in respect of the public interest, the question is wider and includes public confidence in the nursing profession. He reminded the panel of its obligation to evaluate your fitness to practice based on your practice today, informed by the facts found proved, and the other evidence and information before it. He referred the panel to your reflection statements, apologies, oral evidence provided at the misconduct and impairment stages to address the potential ongoing risk your practice poses. He addressed the panel on your remediation in relation to the identified concerns and noted the training that you have undertaken. He accepted that you have not worked in close proximity to IV medications given the interim order that you are currently subject to. He submitted that you have remediated in the ways that you can and that you have significantly mitigated against any ongoing risk. He referred to your professional testimonials and submitted that you have proven yourself to be an invaluable, hard-working, compassionate individual working in a challenging clinical setting. He submitted that the panel would need to consider all of this in making a finding in respect of public confidence and public interest. [PRIVATE]

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor.

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

The panel considered whether you your actions did fall significantly short of the standards expected of a registered nurse, and it determined if your actions amounted to a breach of the Code.

The panel decided that in the circumstances of your case the following paragraphs of the Code were breached:

'Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern …

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively

To achieve this, you must:

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

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

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:

10.3 complete records accurately … taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

To achieve this, you must:

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

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

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

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

The panel appreciated that a breach of the Code does not automatically result in a finding of misconduct and therefore considered each of the charges in turn in relation to whether your conduct amounted to misconduct.

In respect of charge 1, the panel noted its finding of facts. In particular, the panel had regard to the facts that it did not receive any investigation documents in relation to the incident, no copy of the controlled drug book and no copy of the prescription. The panel also noted that it did not have sight of the IV training update which was apparently delivered after the date of this charge. In considering the question of misconduct, the panel noted that you have fully admitted a failure to administer and ensure that Patient A

was administered the correct dosage of morphine. The overdose amounted to x10 and relates to an infant patient. Whilst the panel received no expert evidence in relation to such an overdose of morphine to an infant patient it decided in its professional judgement this incident was so serious as to amount to misconduct. The panel decided that your actions did fall short of what would be properly expected of a registered nurse when administering morphine.

The panel next considered charge 4a. The panel noted that you had completed training in 2017 following the incident outlined in charge 1 but was deeply concerned that a similar incident involving morphine still occurred in 2020. Witness 5, a Senior Consultant at the Trust, described the overdose which underpins charge 4a as a *'near fatal dose',* this was an opinion that you agreed with during your oral evidence on impairment. The panel also had sight of the blood gas result for Patient B which indicated significant deterioration and led to increased respiratory support being required. The panel also considered the witness evidence of Witness 4 who stated in the Trust's local investigation that, *"The three red flags were highlighted…: 1. 4 vials of morphine were taken from the CD cupboard. 2. It was calculated that 3.3mls of morphine sulphate would need to be given. 3. A 10ml syringe was used to administer a bolus dose of morphine sulphate."* The panel noted that you accepted, in your oral evidence, that in hindsight these were red flags. The panel noted that you were a senior nurse assisting a junior nurse with the drug calculation for Patient B. However, the panel acknowledges that you both shared equal responsibility to ensure that a correct dosage of the drug was administered. It was of the view that the basic protocol of drug administration was not followed by you and should have been. The panel therefore determined that your conduct in charge 4a was so serious as to amount to misconduct. The panel decided that your actions did fall short of what would be properly expected of a registered nurse when administering morphine.

In respect of charge 4c, the panel determined that you had not deliberately intended to mislead when you were completing the Datix with the morphine dosage at the end of your shift. The panel noted that you had stated you were tired [PRIVATE] when you completed

the Datix. The panel determined your conduct outlined in charge 4c to be a recording error and was not so serious as to amount to misconduct.

The panel found that your actions in charges 1 and 4a did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the 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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

‘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 determined that limbs a, b and c of the Shipman test are engaged when looking to the past.

The panel next considered the Shipman test looking to the future. In this regard, the panel asked three questions which are formulated in Cohen. Firstly, the panel must ask itself whether the misconduct is easily remediable. Secondly, the panel must consider any evidence of remediation leading to strengthening of practice. In this regard, the panel carefully considered your remorse, insight into your failings and any relevant training that you have undertaken since the charges. Thirdly, in light of the evidence of remediation whether you are highly unlikely to repeat your misconduct.

The panel noted that the charges found proved relate to clinical shortcomings. These shortcomings relate to the administration of medication and record keeping. As such, these clinical failings are easily remediable.

The panel next considered evidence of remorse. The panel carefully considered your extensive oral evidence and written reflective pieces. The panel was satisfied that your remorse was genuine and you did not seek to go behind your culpability. In these circumstances, the panel decided that your expression of remorse was complete.

The panel next considered whether your insight into your failings is fully developed. Again the panel gave careful regard to your oral evidence, written reflective pieces and supporting documentation which included several written references. The panel noted that you made full admissions to all charges that have been found proved at the outset of this hearing. In entering these admissions, the panel notes that you accepted your actions and thereby have some insight into what you have done. During the course of your oral evidence and in your written reflective pieces you have shown an understanding of how your actions put the patients at risk of harm and caused actual harm. It noted you have demonstrated insight into why your actions were wrong and how they have impacted negatively upon the reputation of the nursing profession. The panel also noted that you have apologised during the course of this hearing to the patients' families for your misconduct. Having carefully considered all of the evidence the panel determined that your insight is fully developed.

The panel next turned its attention to the training which you have undertaken since the incidents to address the clinical shortcomings and thereby strengthen your practice. The panel noted that you have successfully undertaken courses in relation to the administration of IV medication and the necessary mathematics to make accurate medication calculations. The panel also noted that you are not currently working in a role that involves drug administration. Consequently, you have not had an opportunity to put the theoretical training from the courses that you have successfully undertaken into practical effect. In these circumstances, the panel is concerned that there is no evidence that you have strengthened your practice in a clinical setting in relation to your failings. Consequently, the panel decided that your fitness to practice is impaired as there is no evidence that the public would be safe in respect of you administering medications. The panel therefore determined that there is a real risk of repetition of the misconduct. The

panel therefore decided that a finding of impairment is necessary on the ground of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest. The panel took into consideration that a fully informed member of the public would be concerned if you were allowed to practise with no restriction.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of three years. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Hoskins invited the panel to impose a conditions of practice order for a period of three years given that the panel has found your fitness to practise currently impaired. He reminded the panel that the sanction imposed on your practice must be proportionate and appropriate in the circumstances. He took the panel through the sanctions it had available to it. He referred the panel to the interim conditions of practice order that you are currently subject to. He provided the panel with amendments to those conditions which he submitted would address the failings in your nursing practice, and would protect the public, and serve the wider public interest. He provided submissions in relation to the aggravating and mitigating features of this case.

The panel also bore in mind Mr Olphert's submissions that the panel must *'start at the bottom of the ladder'* with the least restrictive sanction before '*moving up*', if the sanction does not address the panel's concerns regarding public protection or the wider public interest. He accepted the NMC's submissions on the aggravating features of this case and provided submissions in relation to factors to be considered in relation to your mitigation. He made submissions on the appropriateness in relation to each of the sanctions available to the panel and drew the panel's attention to the areas in which you and the NMC differed on the proposed conditions. He further submitted that a shorter period for the order may be a more proportionate outcome. He referred the panel to the positive work testimonials from your current employment. He told the panel about the impact the current interim order has had on your personal circumstances.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any

sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your conduct and involvement in relation to the drug errors put vulnerable patients at risk of harm and caused actual harm. Your conduct caused concern and great distress to the patients' families.
- You repeated your conduct from 2017 in 2020 and despite completing relevant training you did not demonstrate sustained improved practice and went on to make the second error in 2020.
- You did not prioritise safety in relation to patients under your care by allowing your focus to be distracted by other manageable demands on you.
- You did not adhere to drug protocol and procedures which resulted in a loss of risk prevention and reduced protection of patients.
- At the material time you were an experienced senior nurse assisting a junior nurse (though the panel acknowledged that it was the joint responsibility of both nurses to ensure the correct drug calculation and administration).

The panel also took into account the following mitigating features:

- Evidence of fully developed insight in that you have a good understanding of your wrongdoing, demonstrated full remorse and have apologised to the families affected by your conduct.
- Your early admissions to the charges.
- You have only had a limited chance to address the risks in your practice because your practise has been restricted by an interim order for the last 28 months.
- Your completion of relevant training and detailed reflective pieces.
- [PRIVATE]

- You have worked successfully in a different role under supervision for which you have received several positive testimonials and supervision reports regarding your work.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified, in particular in the panel's judgement that there is an ongoing risk to the public. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG (Reference: SAN-3c) and in particular the following factors which are apparent in your case:

- *There is no evidence of you having harmful deep-seated personality or attitudinal problems;*
- *There are identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining which in your case relate to drug calculations and the administration of intravenous drugs;*

- *Your unblemished career prior to the 2017 incident and your safe practice since the 2020 incident evidenced by both supervision records and professional testimonies confirm that there is no evidence of general incompetence;*
- *You have demonstrated both a potential and willingness to respond positively to retraining;*

The panel accepted that you are willing to comply with a conditions of practice order. The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case and ensure that:

- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel had regard to the fact that you have had an unblemished career for a number of years as a nurse prior to these incidents. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

The panel noted that your employers have been supportive and have provided you with supervision in your current role. It noted the insight and remorse you have demonstrated in relation to your past failings.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order and that any risks to the public would be mitigated.

The panel did consider a suspension order in light of the public confidence issues identified, but determined that this would prevent you maintaining the good progress you

have made in your steps to remediate and strengthen your practice in the defined area of misconduct. The panel was of the view that the public would remain protected by the conditions placed on your registration. The panel noted that there is no evidence of you having a harmful deep-seated personality or attitudinal problems. The panel also noted in its determination at the impairment stage that your insight is now fully developed and that you do not pose a significant risk of repeating your misconduct.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and unduly punitive. It determined that these sanctions would not be a reasonable response in the circumstances of your case because of your fully developed insight. The panel was of the view that any risks to the public would be addressed by a conditions of practice order.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

In reaching its decision to impose a condition of practice order, the panel carefully considered the sanctions guidance, SAN-1, in relation to proportionality when considering sanctions. In particular, the panel noted that *"Being proportionate means finding a fair balance between the nurse, midwife or nursing associate's rights and our overarching objective of public protection. We need to choose a sanction that doesn't go further than we need to meet this objective. This reflects the idea of right-touch regulation, where the right amount of 'regulatory force' is applied to deal with the target risk, but no more… To be proportionate, and not go further than it needs to, the Committee should think about what action it needs to take to protect the public and address the reasons why the nurse, midwife or nursing associate is not currently fit to practise."*

The panel determined that the following conditions are appropriate and proportionate in this case:

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must only work for one substantive employer, which must not be an agency.

2. At any time you work as a registered nurse, you must not be the nurse in charge of a shift where medication is being administered.

3. In any role which involves the administration of intravenous medication, you must:
   a) undertake theoretical and practical training in relation to IV medication administration.
   b) not be involved in the administration of any medication intravenously unless directly supervised.

4. At any time you are working as a registered nurse in a setting involving intravenous drug administration, you must attend monthly supervision meetings with a nominated clinical supervisor, mentor or manager who must be a registered nurse or a registered medical practitioner. At these meetings you must discuss your ongoing competence in relation to medicines administration.

5. At any time you are working as a registered nurse you must provide a report to your case officer from your nominated clinical supervisor, mentor or manager, who must be a registered nurse or a registered medical practitioner, prior to any NMC review hearing or meeting, commenting on your medicines administration, your conduct and

performance as a registered nurse and your compliance with these conditions.

6. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

7. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).
   c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for three years. The panel was of the view that this period would also serve the public interest given the serious nature of the facts found proved. The panel determined that this would allow you to review your career choices and find relevant opportunities to complete the necessary training and practical experience to address the failings identified in your nursing practice in respect of IV drug administration. The panel carefully considered the effect the interim order over the last 28 months on the imposition of this sanction. The panel noted that there is no principle in regulatory law that time spent on an interim order must be deducted from a substantive order. The panel gave careful consideration to the principle of common fairness but determined, in your case, that the seriousness of the overdoses were such that the period on an interim order should not affect the making of or the length of the substantive order

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Evidence of any training or certification that you complete in relation to the administration of IV medication.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Hoskins. He invited the panel to impose an interim conditions of practice order, with the conditions outlined in the panel's substantive order, for a period of 18 months to cover any potential period of appeal. He submitted that any such order would be necessary on the grounds of public interest and public protection.

The panel also took into account the submissions of Mr Olphert. He stated that he did not have any specific submissions in relation to this application and noted that it was a matter of necessity.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The

conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any potential period of appeal.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.