Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday, 31 May 2023- Friday, 2 June 2023

Virtual Meeting

Name of Registrant:	Robyn Connelly
NMC PIN	08I2210S
Part(s) of the register:	Sub part 1 RNA: Adult nurse, level 1 (11 April 2012)
Relevant Location:	Renfrewshire, Scotland
Type of case:	Misconduct
Panel members:	Janet Fisher (Chair, Lay member) Christine Moody (Lay member) Terry Shipperley (Registrant member)
Legal Assessor:	Robin Ince
Hearings Coordinator:	Roshani Wanigasinghe
Facts proved:	All
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

The panel noted at the start of this meeting that the Notice of Meeting had been sent to Miss Connelly's registered email address on 26 April 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, dates and the fact that this meeting was heard virtually. The notice stated that this matter would be considered by a Fitness to Practise panel at a meeting on or after 31 May 2023 and invited Ms Connelly to provide any response or comments by 25 May 2023. The panel noted that no responses or comments had been received from Ms Connelly.

In the light of all of the information available, the panel was satisfied that Ms Connelly has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a Registered Nurse, while working at Ranfurly Care Home:

1. On 31 October 2019:

    a) Prepared dose(s) of diamorphine and/or midazolam for Patient A without having the patient's MAR chart/prescription sheet in front of you.
    [Charge found proved]

    b) Filled the syringe(s) with more than the prescribed amounts of diamorphine and/or midazolam for Patient A. **[Charge found proved]**

    c) Asked Colleague B to sign out controlled drugs when they had not witnessed them being prepared. **[Charge found proved]**

d) Administered the diamorphine and/or midazolam to Patient A without a witness present. **[Charge found proved]**

e) Left the syringes containing the residual diamorphine and midazolam, unattended until prompted to dispose of them. **[Charge found proved]**

f) Asked and/or permitted Colleague A to sign the MAR chart for Patient A when they had not witnessed the administration of the diamorphine and/or midazolam. **[Charge found proved]**

g) Your conduct in Charge 1f was dishonest in that you knew Colleague A had not witnessed the administration of the medication to Patient A. **[Charge found proved]**

2. On 1 November 2019, asked Colleague A to amend the entries made for Patient A on 31 October 2019 in the controlled drugs book in the following columns for the drugs diamorphine:

   a) Amount Given **[Charge found proved]**

   b) Amount Discarded **[Charge found proved]**

3. Your actions at charge 2 demonstrate a lack of candour in that you sought Colleague A's assistance to conceal the incorrect amounts you had recorded. **[Charge found proved]**

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

Decision on the consideration to admit the evidence of Colleague C

The panel noted within the bundle, the NMC's application to adduce the local statement of Deputy Manager, Colleague C, dated 1 November 2019 as hearsay evidence as Colleague C is now deceased.

The panel accepted the advice of the legal assessor who referred to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 Admin. He referred the panel to Rule 31(1) which provides that:

> "*31.(1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence.*"

The legal assessor indicated that there are two considerations when deciding whether a document is admissible, namely whether the statement was relevant to the issues that the panel has to decide (which included matters such as impairment) and, if so, whether it was fair to admit it.

The panel therefore first considered whether Colleague C's statement was relevant. It panel noted that Colleague C's statement offers information on Ms Connelly's actions in raising the concerns to Colleague C. The panel therefore decided that it was relevant as it potentially would assist the panel in making decisions in relation to both facts and impairment.

The panel next considered whether it was fair to admit Colleague C's evidence. It agreed with the NMC's written submissions that Colleague C's Internal Investigation Witness statement was not the sole and decisive evidence; that she is unfortunately not available to provide a statement for the NMC as she is deceased and that the panel can decide what weight to place on the Internal Investigation Witness statement when making its considerations. Moreover, the panel noted that Ms Connelly had not objected to the statement being admitted. The panel was of the view that admitting Colleague C's evidence would be fair to Ms Connelly as it demonstrates that she reported the incident to Colleague C at the time of the allegations.

The panel concluded that Colleague C's evidence was relevant and that it would be fair to admit it into evidence.

Background

The NMC received a referral on 1 November 2019 from the manager at Ranfurly Care Home (the Home). The referral concerned Ms Connelly who was employed as a staff nurse at the Home.

The referral letter advised that Ms Connelly had been suspended on full pay pending an investigation into allegations of "*failure to follow correct process and procedure when checking and administering controlled drugs*".

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence, which included witness statements, and documents from the Home's local investigation.

The panel accepted the advice of the legal assessor.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that 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 therefore considered each charge separately and made the following findings:

The stem of the charge:

That you, a Registered Nurse, while working at Ranfurly Care Home

This stem is found proved.

The panel notes the evidence of the Manager of the Home, who confirmed in her NMC witness statement dated 10 January 2023 that:

"Robyn was employed as a staff nurse at the Home and her responsibilities were clinical tasks that were to be carried out, checking residents when asked by the Senior Care Assistant ('SCA') if any concerns were raised, making clinical decisions regarding calling GP's, ambulance etc. She began her employment on 7 October 2019 and left on 10 December 2019. Issues came to light when the SCA raised concerns following a shift Robyn completed on 31 October 2019 and my deputy was contacted."

Charge 1a

1. *On 31 October 2019:*

a) *Prepared dose(s) of diamorphine and/or midazolam for Patient A without having the patient's MAR chart/prescription sheet in front of you.*

This charge is found proved.

In reaching this decision, the panel took into account the Internal Investigation Witness statement of Colleague A, the notes of the investigatory meeting with Colleague A, Colleague A's witness statement to the NMC and the Controlled Drugs policy.

The panel had sight of the notes of the investigatory meeting with Colleague A held on 19 November 2019, which was a short period after the events in question that took place on 31 October 2019. The notes recorded that, when asked if Ms Connelly and Colleague A had checked the correct prescription against the "*MARS sheet"* Colleague A stated that "*they didn't have any MARS sheet, it was checked against the boxes*". The panel noted that this document was consistent with Colleague A's witness statement to the NMC dated 7 March 2021 which stated the following:

"We checked the quantity of medication there against the prescription label on the box."

The panel further had regard to the Controlled Drugs policy and noted that it states under section 4.5.2, that;

"As with the normal administration procedure the medication must be obtained after checking the MAR sheet to ascertain which medication is due to be given. This must be checked by the second member of staff".

The panel was of the view that Colleague A has provided consistent evidence in respect of this charge. It had no reason not to believe her documentary evidence.

The panel was of the view that, in the absence of any documents or evidence contrary to this from Ms Connelly, it found that on 31 October 2019, Ms Connelly, prepared dose(s) of diamorphine and/or midazolam for Patient A without having the patient's MAR chart/prescription sheet in front of her.

The panel therefore found charge 1a proved.

Charge 1b

1. *On 31 October 2019:*

b) *Filled the syringe(s) with more than the prescribed amounts of diamorphine and/or midazolam for Patient A.*

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's NMC witness statement, the notes of the Internal Investigatory meeting with Colleague A and Colleague B's Internal Investigation witness statement dated 1 November 2019.

The panel had sight of Colleague A's NMC witness statement dated 7 March 2021 which stated:

"She then put the needle into the diamorphine ampule to dilute it. It was quite small so it didn't take all the water. I'm not sure what the dosage should have been to be honest but she drew the whole ampule into the syringe. It could have been 5ml or

10ml, I can't remember, but I'm pretty sure it was 10ml because I compared needle and syringe sizes with my manager the following day. She used a 10ml syringe to draw up the midazolam. It was a 10ml dosage, the amount that was in the ampule. She drew up the whole ampule.

I remember questioning why she'd drawn up the whole of both ampules. The nurses I'd worked with previously and since have only drawn up the amount required. They would do a calculation to work out how much was needed. I should have questioned it but I didn't feel comfortable questioning the senior nurse. Although I did say, almost in a joking manner "oh God you're not going to give all of that are you?" Robyn said "oh no, not a chance. I'm only going to give the two nodules"…"

The panel then had sight of the notes of the Internal Investigatory meeting with Colleague A held on 19 November 2019, which records:

"[Colleague A] said to her your not going to give all that, RC said 'oh god no' I'm going to give two nodules [sic]*"*

The panel also had sight of Colleague B's Internal Investigation witness statement dated 1 November 2019 where she wrote:

"I also asked why she had drew up all this medication when the other nurses usually only drew up what the residents states dose is and discard the rest. She then said this is the way she does it and will keep the remainder in case this resident needs more later. [sic]*"*

The panel noted, from the Controlled Drug book, that the appropriate dose of diamorphine for Patient A was 2mg and that the ampule contained 5mg. Further, it stated that 2mg were given and 3mg discarded. It therefore followed that, if Ms Connelly drew all of the contents of the 5mg ampule (albeit diluted with some water) into the syringe, the syringe contained 5mg of diamorphine which was more than the prescribed amount of 2mg.

Similarly, the panel further noted, again from the Controlled Drug book, that the appropriate dose of midazolam for Patient A was 2mg and that the ampule contained

10mg. Further, it stated that 2mg were given and 8mg discarded. It therefore followed that, if Ms Connelly drew all of the contents of the 10mg ampule into the syringe, it follows that the syringe contained 10mg of midazolam which was more than the prescribed amount of 2mg.

The panel was satisfied that both Colleague A's and Colleague B's evidence was consistent and corroborated one another. It was of the view that they provided clear explanations as to what the normal practice was, and that Ms Connelly had drawn more than the prescribed amounts of medication into each syringe at one time.

The panel therefore concluded that on 31 October 2019, Ms Connelly filled the syringe(s) with more than the prescribed amounts of diamorphine and/or midazolam for Patient A. The panel therefore found charge 1b proved.

Charge 1c

1. *On 31 October 2019:*

c) *Asked Colleague B to sign out controlled drugs when they had not witnessed them being prepared.*

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's NMC witness statement and notes of Internal Investigatory meeting with Colleague B.

The panel noted that Colleague B in her NMC witness statement dated 12 January 2023 wrote:

> *"Robyn had asked me to sign out Controlled Drugs but I told her I was not comfortable to do this as she had already drew the medication into the syringe without this being witnessed. This would have gone against the Home's Controlled Drug policy and process which is why I said no.* [sic]*"*

The panel also had sight of the notes of the Internal Investigatory meeting with Colleague B held on 27 November 2019 where it stated:

> "*RC asked [Colleague B] to sign for the medication. [Colleague B] explained that she couldn't sign for them as she didn't see them being drawn up to which RC replied she would ask [Colleague A] to sign as she had seen them being drawn up…*"

The panel was satisfied that Colleague B provided clear explanations to this charge. The panel bore in mind that their explanations were consistent, and they would have no reason to create a false statement.

The panel further noted that Ms Connelly has not provided any response in relation to this charge.

Given all the evidence above, and the lack of any further information from Ms Connelly the panel was satisfied that on 31 October 2019, Ms Connelly asked Colleague B to sign out controlled drugs when they had not witnessed them being prepared.

The panel therefore found charge 1c proved.

Charge 1d

1. *On 31 October 2019:*

d) *Administered the diamorphine and/or midazolam to Patient A without a witness present.*

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's Internal Investigation witness statement and Colleague C's Internal Investigation Witness Statement.

The panel had sight of Colleague B's Internal Investigation witness statement dated 1 November 2019 where she wrote:

> *"Robin then said to me would you feel more comfortable if I dispose of the drugs and syringes. I asked her if she had given this resident anything, which she stated yes, I said who was with you and she said she did it herself."*

The panel also had sight of Colleague C's Internal Investigation Witness Statement dated 1 November 2019 where she wrote that in her telephone conversation with Ms Connelly, she acknowledged she had administered medication and that they had some discussion on what quantity was administered. Further she wrote that when asked if Colleague A or Colleague B had been present during this administration, Ms Connelly had said she administered the medication herself.

The panel noted that Ms Connelly has not provided any response in relation to this charge.

Given the lack of any contrary suggestion by Ms Connelly, and given the apparent admission internally of her administering mediation without anyone being present, the panel was satisfied that it had sufficient information before it to find that on 31 October 2019, Ms Connelly administered the diamorphine and/or midazolam to Patient A without a witness present.

The panel therefore found charge 1d proved.

Charge 1e

1. *On 31 October 2019:*

e) *Left the syringes containing the residual diamorphine and midazolam, unattended until prompted to dispose of them.*

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's NMC witness statement and Colleague C's Internal Investigation Witness Statement.

The panel had sight of Colleague A's NMC witness statement dated 7 March 2021 which stated:

> *"The syringes with the needles attached with the medication we'd, Robyn and I, drawn up previously were lying on the work surface. It looked like some of the medication had been administered and the leftovers had been left in the syringes which were lying on the work surface, which should never ever happen.*
> *…*
> *Robyn came looking like she'd been crying and was panicky. She said "I shouldn't have left the syringes but when I worked in the hospital we were able to leave them and reused them…"*

The panel also had sight of Colleague C's Internal Investigation Witness Statement dated 1 November 2019 where she wrote:

> *"SN Connelly said no she had given the right amount and kept the remainder in case she had to give more later."*

The panel also reminded itself that Colleague A described in her NMC witness statement that this had been drawn to her attention by a colleague as the syringes were left unattended.

The panel noted that Ms Connelly has not provided any response in relation to this charge.

Given the lack of any contrary information by Ms Connelly and given the consistent evidence from Colleague A and Colleague C and the panel's view that their evidence was reliable in respect of this charge, the panel was satisfied that it had sufficient information before it to find that on 31 October 2019, Ms Connelly left the syringes containing the residual diamorphine and midazolam, unattended until prompted to dispose of them.

The panel therefore found charge 1e proved.

Charge 1f

1. *On 31 October 2019:*

f) Asked and/or permitted Colleague A to sign the MAR chart for Patient A when they had not witnessed the administration of the diamorphine and/or midazolam.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's NMC witness statement and Colleague A's Internal Investigation witness statement dated 1 October 2019.

The panel had sight of Colleague A's NMC witness statement dated 7 March 2021 which stated:

> *"She came back into the unit and asked to me to sign the MAR sheet. I asked was [*Colleague B*], the other Senior Care Assistant, upstairs and Robyn said she'd helped administer the medication. I signed the MAR sheet… I assumed it was ok to do this because I'd drawn up the medication with her. I now know this wasn't ok. It should have been the same person witnessing the medication being drawn up and it being given…"*

The panel also had sight of Colleague A's Internal Investigation witness statement dated 1 October 2019 in which she wrote:

> *"About 10 mins later, Robyn came back & told me SCA [*Colleague B*] was not happy to sign the mar as she hadn't known anything about this. I agreed to sign, purely because I had watched the drugs be drawn up & assumed at the time [*Colleague B*] had witnessed the administration. It was only later I found out [*Colleague B*] hadn't & realised I was in the wrong."*

The panel bore in mind that Ms Connelly has not provided any response in relation to this charge.

Given the lack of any contrary information by Ms Connelly and given the consistent evidence from Colleague A and the panel's view that her evidence was reliable in respect of this charge, the panel was satisfied that it had sufficient information before it to find that on 31 October 2019, Ms Connelly asked and/or permitted Colleague A to sign the MAR chart for Patient A when they had not witnessed the administration of the diamorphine and/or midazolam.

The panel therefore found charge 1f proved.

Charge 1g

1. *On 31 October 2019:*

g) *Your conduct in Charge 1f was dishonest in that you knew Colleague A had not witnessed the administration of the medication to Patient A.*

This charge is found proved.

In reaching this decision, the panel took into account its decision at charge 1f above. It also considered the NMC Code of Conduct, the NMC Guidance on *'Making decisions on Dishonesty charges'* as well as the test set out in the case of *Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67*.

The panel bore in mind that the NMC Code of Conduct is clear on expectations around adhering to guidance given to staff about administration of medication. The panel found that Ms Connelly was fully aware that no other member of staff was present when she administered the diamorphine and/or midazolam. Therefore, asking and/or permitting Colleague A, to sign the MAR chart on 31 October 2019 for Patient A when they had not witnessed the administration of the diamorphine and/or midazolam must have been dishonest. The panel could think of no other possible interpretation of such action and noted that there was no alternative explanation from Ms Connelly to this charge.

The panel was of the view that a well-informed member of the public, fully aware of all the facts of this case, would find Ms Connelly's actions at charge 1f to be dishonest.

Given the above information, the panel concluded that Ms Connolly's actions at charge 1f were dishonest in that she knew Colleague A had not witnessed the administration of the medication to Patient A.

In light of this evidence, the panel found charge 1g, on the balance of probabilities, proved.

Charge 2

2. *On 1 November 2019, asked Colleague A to amend the entries made for Patient A on 31 October 2019 in the controlled drugs book in the following columns for the drugs diamorphine:*

a) *Amount Given*

b) *Amount Discarded*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account Colleague A's NMC witness statement, the relevant page in the controlled drug book for this charge, and the notes from the Internal Investigatory meeting with Colleague A dated 27 November 2019.

The panel had sight of Colleague A's NMC witness statement dated 7 March 2021 which stated:

> *"I came in the next day about 07:45 and Robyn asked me if she could speak to me in private. She had the controlled drug book open at the page we'd completed the night before. She said she'd written the wrong numbers for the diamorphine but administered the correct dose. I think I she said 2 and 8 was what she'd written down but I can't remember. She said it should have been 0.2 and 0.8 because it had been diluted with water. She asked if I would correct and sign the book with*

her. I refused and said "we're up shit creek here, we should just hold out hands up to the mistakes…"

The panel had sight of the relevant page from the controlled drug book for this charge. It noted that, in respect of the diamorphine, within the '*amount given*' column it is recorded as 2mg and below it has a correction of 0.2ml. The panel also noted that within the '*amount discarded*' column it is recorded as 3mg and below it has a correction of 0.8ml. Similarly, in respect of the midazolam, within the '*amount given*' column it is recorded as 2mg and below it has a correction of 0.2ml. The panel also noted that within the '*amount discarded*' column it is recorded as 8mg and below it has a correction of 1.8ml.

The panel also took account that within the notes from the Internal Investigatory meeting with Colleague A dated 27 November 2019, which recorded:

*"[*Colleague A*] was in early morning and RC asked if she could have a word in private with her. RC said to [*Colleague A*] that she would need to correct digits in the book it was correct she just had put just to put the digits in the wrong place. [The Manager at the Home] asked [*Colleague A*] if she had went with her, [*Colleague A*] said that she had RC said that she had written 2mls and 8mls it should have been 0.2 mls and 0.8mls."*

The panel noted that Ms Connelly has not provided any response in relation to this charge.

Given the consistent evidence from Colleague A and the amended controlled drugs page the panel determined that it had satisfactory information before it to find that on 1 November 2019, Ms Connelly asked Colleague A to amend the entries made for Patient A on 31 October 2019 in the controlled drugs book in the following columns for the drugs diamorphine; Amount Given and Amount Discarded.

The panel therefore found charge 2 in its entirety proved.

Charge 3

3. *Your actions at charge 2 demonstrate a lack of candour in that you sought Colleague A's assistance to conceal the incorrect amounts you had recorded.*

This charge is found proved.

In reaching this decision, the panel took into account its decision at charge 2 above and the NMC Guidance on Duty of Candour last updated in March 2022.

The panel first bore in mind the Guidance where it states the following:

> *"Your duty to be open and honest with your organisation, and to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses"*

The panel bore in mind that it is a professional's responsibility to correct things when they go wrong. The panel reminded itself of Ms Connelly's position as a registered nurse at the Home. It also bore in mind that Colleague A, was a junior colleague and Ms Connelly asked Colleague A to amend the entries made for Patient A on 31 October 2019 in the controlled drugs book when she should not have.

The panel found that Ms Connelly has not provided any evidence in respect of this charge.

By acting in such a way as found in charge 2, the panel determined that Ms Connelly demonstrated a lack of candour in that she sought Colleague A's assistance to conceal the incorrect amounts she had recorded.

The panel therefore found charge 3 proved.

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 Ms Connelly's fitness to practise is currently impaired. There is no statutory definition of fitness

to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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, Ms Connelly's fitness to practise is currently impaired as a result of that misconduct.

Decision and reasons on misconduct

When making its decision, the panel had regard to the advice of the legal assessor and the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) updated in 2018. It also had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

In coming to its decision, the panel had regard 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.'*

The panel was of the view that Ms Connelly's actions fell significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

8 Work co-operatively

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

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

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

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

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

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

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

18.4 take all steps to keep medicines stored securely

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

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

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.4 keep to the laws of the country in which you are practising
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Connelly breached the Home's Controlled Drugs Policy; prepared doses of controlled drugs without having the patient's MAR chart/prescription sheet in front of her; filled syringes with more than the prescribed doses of two controlled drugs (which appeared to involve estimating how much should be given); asked a colleague to confirm, by signature, actions which they had not witnessed, which the panel found to have been dishonest; left used syringes containing residual controlled drugs unattended; and asked a colleague to amend incorrect entries in the controlled drugs book, which the panel found amounted to a lack of candour. The panel determined that, although no patients were caused direct harm, there was a risk to patients in that incorrect amounts of controlled drugs could have been given and patients/others could have had access to controlled drugs to which they were not entitled. Furthermore, the panel was of the view that dishonesty is inherently considered to be a serious matter which the panel have found in this case.

The panel therefore, considering all the matters above, found that Ms Connelly's actions 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, Ms Connelly's fitness to practise is currently impaired.

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

In this regard the panel considered the 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that all limbs of the Grant test are engaged in this case, both as to the past and the future. At the time of these incidents, Ms Connelly's misconduct placed vulnerable residents at unwarranted risk of harm, brought the nursing profession into disrepute, and breached fundamental tenets of the nursing profession, relating to a failure to follow correct process and procedure when checking and administering controlled drugs which included dishonesty and a lack of candour.

The panel turned its consideration to matters of current impairment. In its consideration of whether Ms Connelly has addressed the failures in her practice, it bore in mind that the charges found proved include dishonesty. The panel considered that the dishonesty and lack of candour found proved was capable of demonstrating a pattern of behaviour, particularly as it was repeated with at least two colleagues, and therefore, arguably, to be attitudinal and determined it is therefore not easily remediable.

Ms Connelly has made no acknowledgement of wrongdoing, save for a partial admission when she reported the matter to Colleague C. The panel has no information before it from Ms Connelly regarding any steps she has taken to address these concerns. The panel therefore had no evidence of insight into Ms Connelly's misconduct.

The panel determined that Ms Connelly's misconduct involved wide ranging failings in relation to her basic duties as a nurse impacting on basic nursing care. It noted that Ms

Connelly's misconduct put residents at risk of harm, and the panel is of the view that in the absence of any evidence of strengthening her practice, the risk of repetition remains.

Further, the panel bore in mind that these concerns had come to light whilst Ms Connelly was subject to another referral to the NMC regarding similar allegations. These were that, in November 2017, at another care home, Ms Connelly did not administer required medication to a number of residents but nonetheless signed the MAR charts of those residents to show that their medication had been administered, when it had not been. Further, those actions were alleged to be dishonest in that Ms Connelly knew that she had not administered the required medication but signed the resident MAR charts to show that it had been administered. Further, she was alleged to have lied to colleagues about her having permission from management to use an empty resident's room in which to lie down and rest, which actions were also alleged to be dishonest. Subsequently, in August 2021, a fitness to practise panel had found those particular charges (together with a number of other charges relating to treatment of patients) proved against Ms Connelly and imposed a 12 month suspension order. This had been reviewed in August 2022 and the suspension order extended by six months. A further review in March 2023 had imposed a further extension of six months. Ms Connelly did not attend any of these three hearings, with all three panels finding that she had not demonstrated any insight into her dishonesty. In these circumstances, this panel found that the risk of repetition is very high. The panel therefore determined that, in this case, a finding of impairment on public protection grounds was required.

The panel bore in mind that the overarching objectives of the NMC is to protect, promote and maintain the health, safety, and wellbeing 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 had regard to the serious nature of Ms Connelly's failings and determined that public confidence in the profession, particularly as it involved dishonesty in clinical care, would be undermined if a finding of current impairment was not made. For this reason, the panel determined that a finding of current impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Ms Connelly's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

Having found Ms Connelly's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Connelly off the register. The effect of this order is that the NMC register will show that Ms Connelly 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 and had careful regard to the Sanctions Guidance (SG) published by the NMC.

The panel accepted the advice of the legal assessor, who also reminded the panel that it was to act proportionately.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 26 April 2023, the NMC had advised Ms Connelly that it would seek the imposition of a striking-off order if the panel found Ms Connelly's fitness to practise currently impaired. In particular, the NMC submitted:

> "*58. Taking the least serious sanctions first, it is submitted that taking no action or imposing a caution order would not be appropriate in this case. The* ***NMC Sanctions Guidance*** *("the Guidance") states that taking no action will be rare at the sanction stage and this would not be suitable where the nurse presents a continuing risk to patients. In order to achieve the overarching objective of public protection, action in this case is required to secure patient safety, to secure public trust in nurses, midwives and nursing associates and to promote and maintain proper professional standards and conduct. The seriousness of the misconduct in this case means that taking no action would not be appropriate. A caution order*

would also not be appropriate as this would not mark the seriousness and would be insufficient to protect the public from harm, maintain high standards within the profession or the trust the public place in the profession. Additionally, neither sanction would restrict Miss Connelly from practising.

59. The Guidance (SAN-3c) states that a conditions of practice order is appropriate when the concerns can easily be remediated and when conditions can be put in place that will be sufficient to protect the public and address the areas of concern to uphold public confidence. In this case, a conditions of practice order would not protect the public, and would not be in the public interest. Due to the existence of what appear to be underlying harmful deep-seated attitudinal concerns, it is not considered that suitable and workable conditions could be formulated. Moreover, a conditions of practice order would not be sufficient to mark the seriousness of the concerns.

60. According to the Guidance (SAN-d), a suspension order may be appropriate when the registered professional has shown insight and does not pose a significant risk of repeating the behaviour. However, Miss Connelly has not shown any insight into the concerns raised or provided evidence that the behaviour will not be repeated, her lack of engagement is indicative of the continuing deep seated attitudinal concerns. Taking into account the nature and seriousness of the conduct, temporary suspension from the register would be insufficient to protect patients, public confidence in nurses, the NMC as its regulator and professional standards.

61. Furthermore, the Guidance (SAN-3e) states that a striking-off order is likely to be appropriate when what the nurse has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:

• Do the regulatory concerns about the nurse raise fundamental questions about their professionalism?

• Can public confidence in nurses be maintained if the nurse, midwife or nursing associate is not removed from the register?

• Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?

62. The regulatory concerns about Miss Connelly raises fundamental questions about her professionalism, not only did she fail to follow basics of nursing in controlled drug administration, she acted dishonestly in requesting a colleague sign the administration knowing that they had not witnessed it, and attempted to conceal a medication error.

63. Public confidence in the profession cannot be maintained if Miss Connelly is not struck off from the register and a striking off order is the only appropriate sanction to protect patients and maintain professional standards.

64. Allegations of dishonesty in drug record keeping are extremely serious and raised fundamental questions about Miss Connelly's professionalism. Taking into account, Miss Connelly's previous fitness to practise history, there is a need to ensure public confidence in the professional and professional standards are maintained.

65. Therefore taking in account the serious nature of the concerns together with the aggravating and mitigating factors striking Miss Connelly from the register would be proportionate and appropriate."

The panel noted that Ms Connelly has not provided any responses.

Decision and reasons on sanction

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.

[PRIVATE]

[PRIVATE]

The panel took into account the following aggravating features:

- Previous regulatory findings for very similar concerns suggesting a pattern of behaviour;
- Ms Connelly sought to involve a junior colleague in her dishonesty;
- She put patients at risk of harm; and
- There was no evidence of insight and/or reflection as to her misconduct.

The panel also took into account the following mitigating features:

- **[PRIVATE]**; and
- She reported part of the incident to her Deputy Manager during the shift in which it had occurred.

The panel considered the level of Ms Connelly's dishonesty in accordance with the SG. It considered her dishonesty to be at the upper end of the spectrum as Ms Connelly deliberately asked a colleague to confirm, by signature, actions which they had not witnessed. The panel bore in mind that the dishonesty was in a clinical setting and there was a consequential risk of patient harm. Further, this involved a deliberate breach of her duty of care and involved misleading other junior colleagues as to the actions conducted by her. It further bore in mind that Ms Connelly asked a colleague to amend incorrect entries in the controlled drugs book, which the panel found amounted to a lack of candour.

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 Ms Connelly's 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 Ms Connelly's

misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Connelly's registration would be a sufficient and appropriate response. The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Whilst the panel was of the view that some of the clinical concerns could have been addressed through a conditions of practice order, the panel determined that given the seriousness of the misconduct, Ms Connelly's apparent attitudinal concerns displayed by her repeated acts of dishonesty in 2017 and 2019 and her lack of insight into those actions, there are no practical or workable conditions that could be formulated. Accordingly, a conditions of practice order would not address the significant risk of repetition. In addition, the panel had no evidence before it to suggest that Ms Connelly would comply with any conditions of practice. Furthermore, the panel concluded that the placing of conditions on Ms Connelly's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *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 conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. This was not a single instance of misconduct, furthermore the panel considered there was evidence of attitudinal problems. The clinical concerns in this case involved dishonesty and a lack of candour. The panel bore in mind that Ms Connelly has provided no explanation for her actions, neither has she

demonstrated any insight or remorse. Finally, the panel noted that Ms Connelly had been suspended from practice from August 2021 but had not engaged with two review hearings, which strongly suggested to the panel that suspension was not an effective sanction and had achieved nothing by way of remediating Ms Connelly's failings. Therefore, the panel concluded that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional, which may involve 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 within 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.*
- *Dishonesty, especially where persistent or covered up.*
- *Persistent lack of insight into seriousness of actions or consequences.'*

The panel determined that Ms Connelly's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her

remaining on the register. Further, although no harm was caused to any patient, her actions (which appeared to involve estimating how much medication was to be given) could have caused significant harm. Not only did her actions involve dishonesty and a lack of candour on more than one occasion, there was an attempt to cover up what she had done. Finally, Ms Connelly has displayed a persistent lack of insight into the seriousness of her actions. Accordingly, all of the factors listed above are present. The panel was also of the view that the findings in this particular case demonstrate that Ms Connelly's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel noted the hardship such an order will inevitably cause Ms Connelly, although she has not provided it with any information about her current circumstances. However, the panel considered that this is outweighed by the public interest in this case.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Connelly's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel determined that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Ms Connelly in writing.

Interim order

As the striking-off 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 Ms Connelly's own interest

until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that if a finding is made that Ms Connelly's fitness to practise is impaired on a public protection and public interest basis and a restrictive sanction imposed, the NMC consider an 18 month interim suspension order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order to adequately protect the public if this order is appealed. This order is for a period of 18 months to allow time for any appeal to progress.

If no appeal is made, then the interim suspension order will be replaced by the substantive striking off order 28 days after Ms Connelly is sent the decision of this hearing in writing.

That concludes this determination.