Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 18 September 2023 – Friday, 22 September 2023
&
Monday, 25 September 2023

Virtual Hearing

Name of Registrant:	**Felicity Clare Cantrell**
NMC PIN	79E0923E
Part(s) of the register:	Registered Nurse RN2: Adult Nursing L2 – May 1980 RN1: Adult Nursing L1 – March 1986
Relevant Location:	Dorset
Type of case:	Misconduct
Panel members:	Florence Mitchell (Chair, Registrant member) Catherine Cooper (Registrant member) Jan Bilton (Lay member)
Legal Assessor:	Andrew Young (18 – 19 September 2023) Gerard Coll (20 – 22 September & 25 September 2023)
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Ms Shekyena Marcelle-Brown, Case Presenter
Mrs Cantrell:	Not present and unrepresented
Facts proved:	5a, 5b, 7a, 7b, 8, 9.2a, 9.2b, 9.3, 9.5 and 9.6
Facts not proved:	1a, 1b, 2, 3a, 3b, 4, 6, 9.1a, 9.1b, 9.1c, 9.4 and 9.7
Fitness to practise:	Impaired

Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Cantrell was not in attendance and that the Notice of Hearing letter had been sent to Mrs Cantrell's registered email address by secure email on 10 August 2023.

Ms Marcelle-Brown, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Cantrell's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Cantrell has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Cantrell

The panel next considered whether it should proceed in the absence of Mrs Cantrell. It had regard to Rule 21 and heard the submissions of Ms Marcelle-Brown who invited the panel to continue in the absence of Mrs Cantrell. She submitted that Mrs Cantrell had voluntarily absented herself.

Ms Marcelle-Brown referred to an email from Mrs Cantrell dated 4 April 2022. She submitted that this email is the only communication received by the NMC from Mrs Cantrell. She informed the panel that the NMC has made efforts to try and contact Mrs

Cantrell via email and on her registered contact number. She submitted that all reasonable efforts have been made to serve the notice of hearing to Mrs Cantrell.

Ms Marcelle-Brown submitted that there had been no engagement at all by Mrs Cantrell with the NMC in relation to these proceedings apart from her email dated 4 April 2022 to which the panel was told she had received a reply from the NMC. As a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Cantrell. In reaching this decision, the panel has considered the submissions of Ms Marcelle-Brown and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] 1 WLR 3867 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Cantrell;
- Mrs Cantrell has not engaged with the NMC since April 2022 and has not responded to any of the letters sent to her about this hearing;
- Mrs Cantrell has not provided the NMC with details of how she may be contacted other than her registered contact details;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses have been warned to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Some of the charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Cantrell in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address. The panel noted that there are charges in this case which relate to dishonesty which may be difficult to determine in the absence of Mrs Cantrell. However, it noted that it has available to it her accounts of some of the clinical incidents which it can take into consideration when deciding on the facts. The panel noted that Mrs Cantrell will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Cantrell's own decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

The panel also noted that the last communication the NMC has received from Mrs Cantrell was in April 2022 and since then all reasonable efforts have been made by the NMC to try and contact Mrs Cantrell. It noted that the email address on record for Mrs Cantrell is still in existence and so is the contact number but despite this, Mrs Cantrell has been unreachable in the sense that she has not responded to any of the communications from the NMC.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Marcelle-Brown under Rule 31 to allow the paragraphs 13, 20, 21, 29, 36 and 40 of the written statement of Witness 1 into evidence. She set out for the panel that paragraph 13 speaks to charge 1, paragraph 20 speaks to charge 2, paragraph 21 speaks to charge 3, paragraph 29 speaks to charge 5, paragraph 36 speaks to charge 7 and paragraph 40 speaks to charge 8.

Ms Marcelle-Brown also made the application in relation to Exhibit [Witness 1]/44 which is a local statement by Person 1 that speaks to charge 8 and Exhibit [Witness 1]/32, a local statement by Person 2 which speaks to charge 9 including the sub particulars.

Ms Marcelle-Brown submitted that the documentary evidence she makes the application in relation to meets the requirement of relevance.

Ms Marcelle-Brown referred the panel to the case of Thorneycroft v NMC [2014] EWHC 1565 (Admin) which is authority for the factors to be considered when deciding whether to admit hearsay evidence. The factors to be considered are set out in the case of Thorneycroft as follows:

> *'(i) whether the statements were the sole or decisive evidence in support of the charges;*
> *(ii) the nature and extent of the challenge to the contents of the statements;*
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*

(v) whether there was a good reason for the non-attendance of the witnesses;
(vi) whether the Respondent had taken reasonable steps to secure their attendance; and
(vi) the fact that the Appellant did not have prior notice that the witness statements were to be read.'

In respect of limb (i), she submitted that the passages from Witness 1's statement are not the sole and decisive evidence which speak to the charges. She submitted that the relevant paragraphs relate to allegations which were reported to Witness 1 in her capacity as Home Manager. Ms Marcelle-Brown informed the panel that Witness 1 followed up these reports and carried out her own investigation and therefore became a direct witness of what is alleged, based on her findings. She submitted that Exhibits [Witness 1]/32 and [Witness 1]/44 are also not the sole and decisive evidence in relation to any of the charges. She stated that although they were produced by individuals who were direct witnesses of the incidents and not attending this hearing as witnesses, they were followed up by Witness 1 in the course of her investigation.

In respect of limb (ii), Ms Marcelle-Brown submitted that there is not much challenge to the exhibits. She told the panel that during meetings between Mrs Cantrell and Witness 1, Mrs Cantrell made a number of admissions documented within the exhibits before the panel. Likewise, the passages of Witness 1's statements were accepted by Mrs Cantrell during the local meetings. She submitted that any challenge to the contents can be dealt with at a later stage when the panel determine what weight to give these documents.

Ms Marcelle-Brown informed the panel, in respect of limb (iii), there does not appear to be any reason for or suggestion of fabrication. She stated that Mrs Cantrell made acceptance to the factual allegations at a local stage.

In relation to limb (iv), Ms Marcelle-Brown submitted that this is a serious case which involves allegations of dishonesty. There is a public interest in all of the issues in this case being properly explored. She submitted this supports the admission of hearsay evidence.

Further, she submitted any potential impact of an adverse finding on Mrs Cantrell's career is outweighed by the public interest in these issues being explored properly.

In respect of limbs (v) and (vi), Ms Marcelle-Brown submitted that the reason for Person 1 and Person 2's non-attendance at this hearing is not confirmed. She submitted that it may be that in light of the admissions that were made by Mrs Cantrell at the local level, it may be that a decision was made by the NMC not to contact these witnesses, as it was clear that factual allegations were accepted at a local level.

Ms Marcelle-Brown submitted that, in relation to limb (vii), Mrs Cantrell will have been well aware of what the NMC sought to rely on in this case. She stated that Mrs Cantrell was sent a case management form (CMF) in March 2023, which indicated specifically that Exhibit [Witness 1]/44 is hearsay. She submitted that whilst the CMF did not indicate that the passages from Witness 1's statement and Exhibit [Witness 1]/32 was hearsay, those parts of the evidence are not contentious considering the admissions that she made at the local stage.

In closing, Ms Marcelle-Brown invited the panel to admit these documents into evidence. She referred the panel to the NMC guidance on hearsay. She submitted that the admission of the hearsay evidence does meet the fairness and relevance requirements in this case.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave regard to the guidance as set out in the case of Thorneycroft. It also gave consideration to the NMC's guidance on hearsay evidence.

The panel gave the application in relation to the paragraphs 13, 20, 21, 29, 36 and 40 of Witness 1's statement serious consideration. The panel noted that Witness 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her. The panel considered each paragraph individually.

In respect of paragraph 13, it noted that this relates to the alleged medication error on 24 August 2019. The panel noted that this paragraph relates to the pots of medication being left unattended. It noted that it did not have available to it first-hand evidence in relation to this from the member of staff who discovered the pots of medication. However, it did have regard to the outcome letter dated 20 September 2019 which discussed the medication errors and the resultant actions taken by the Home to address them.

The panel considered paragraphs 20 and 21 which relate to the alleged medication errors on 2 November 2019 and 24 November 2019 respectively. The panel noted that this evidence was not the sole or decisive evidence in relation to the relevant charges and that there is further evidence, namely notes of an investigation interview dated 10 December 2019 signed by Mrs Cantrell in support of the charges.

The panel next considered paragraph 29 which relates to an alleged medication error on 5 March 2020. The panel noted that in support of this allegation, it also had regard to Resident G's Medication Administration Record (MAR) chart as well as photographic evidence.

In relation to paragraph 36 which relates to the alleged medication errors of 5 – 6 November 2021. The panel noted that it had regard to the minutes of the disciplinary hearing, the outcome letter for that meeting and an accident and incident analysis form which speaks to the relevant charge.

In relation to paragraph 40 which relates to the alleged medication error on 29 November 2021. The panel noted that there is further evidence which speaks to the relevant charge

including investigation interview notes dated 6 December 2021 and minutes of the disciplinary hearing.

The panel next considered Exhibits [Witness 1]/32 and [Witness 1]/44. It noted that these documents are not the sole or decisive evidence in support of the relevant charges. It noted that Exhibit [Witness 1]/32 is relevant to charge 9 and that Witness 2 gave live evidence which speaks to this charge. In relation to Exhibit [Witness 1]/44, it noted that this is relevant to charge 8, and is supported by paragraph 40 of Witness 1's statement as well as further documentary evidence as mentioned above.

The panel noted that within the documentary evidence, there is indication of Mrs Cantrell's acceptance of the factual allegations and therefore it determined that she does not appear to challenge the evidence. The panel concluded that these are serious matters and that there has been no suggestion of any fabrication on the parts of those witnesses who have first-hand knowledge of these matters.

The panel considered whether Mrs Cantrell would be disadvantaged by the admission of the hearsay evidence. The panel noted that in the preparation of this hearing, the NMC had provided the CMF to Mrs Cantrell in which it informed her of the evidence it sought to rely on. The panel further noted that despite knowledge of the nature of the evidence Mrs Cantrell, has not disputed any of the charges and has made the decision not to attend this hearing. The panel noted that Mrs Cantrell has chosen to absent herself from these proceedings and therefore would not be in a position to challenge the evidence in any case. The panel has also taken into account the fact that the hearsay evidence was not the sole or decisive evidence in relation to any of the relevant charges. On this basis, the panel determined that there was no lack of fairness to Mrs Cantrell in admitting the passages from Witness 1's statement and Exhibits [Witness 1]/32 and [Witness 1]/44 into evidence.

The panel concluded that there is a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. In these circumstances,

the panel came to the view that it would be fair and relevant to admit paragraphs 13, 20, 21, 29, 36 and 40 as well as Exhibits [Witness 1]/32 and [Witness 1]/44 into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Details of charge

"That you a registered nurse, whilst working at the Abbey View Care Home;

1. On 24 August 2019 left medication for one or more of the following residents unattended on the drugs trolley;
    a. Resident A;
    b. Resident B;

2. On 2 November 2019 did not give Resident B their medication which was due.

3. On 24 November 2019;
    a. Did not administer medication which was due to Resident D.
    b. Recorded that you had administered medication which was due to Resident D.

4. Your actions at charge 3 were dishonest in that you sought to create the impression that you had administered the medication to Resident D when you knew you had not.

5. On 5 March 2020 recorded that you had administered one or more of the following medications to Resident G when you had not.
    a. Pyridostigmine;
    b. Omeprazole.

6. Your actions at charge 5 were dishonest in that you sought to create the impression that you had administered the medication when you knew you had not.

7. On the night shift of 5/6 November 2021;
    a. Administered the wrong medication to Resident H
    b. Recorded that you had given resident H the correct medication which was incorrect.

8. On 29 November 2021 administered an antibiotic to Resident D which was meant for Resident I.

9. On 5 January 2022;

9.1 Left one or more of the following medications unattended on the medication trolley

a. Co-Beneldopa
b. Pregablin
c. Simivastatin

9.2 Did not administer one or more of the following medications to Resident E

a. Co-Beneldopa;
b. Pregablin.

9.3 Recorded that you had given one or more of the medications specified at charge 9.2 to Resident E when you had not.

9.4 Your actions at charge 9.3 were dishonest in that you sought to create the impression that you had given Resident E one or more of the medications listed at charge 9.2 when you knew you had not.

9.5 Did not administer Simvastatin to Resident F.

9.6 Recorded that you had given Simivastatin to Resident F when you had not.

9.7 Your actions at charge 9.6 were dishonest in that you sought to create the impression that you had given Resident F Simivastatin when you knew you had not

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

Background

The charges arose whilst Mrs Cantrell was employed as a registered nurse at Abbey View Care Home (the Home). The NMC received a referral on 11 March 2022 in relation to alleged medication administration failures and record keeping failures.

It is alleged that in August 2019, Mrs Cantrell left two pots of medication unattended on a drug trolley. As a result of this alleged incident, Mrs Cantrell was issued a letter of concern and was interviewed at a local investigation meeting where she made admissions in relation to this allegation. She was placed on day shifts for a period of two weeks and was required to undergo a drug competency reassessment with a senior nurse, which she was signed off as successfully completing.

In November 2019, it's alleged that Mrs Cantrell failed to administer medication that was due to residents and then subsequently signed the medication administration record (MAR) charts to indicate that the medications had been administered when it had not. Mrs Cantrell was interviewed at a local level and made admissions in relation to these allegations despite being up to date on the relevant training at the Home and the Home's medication management policy, which did not allow pre-potting medication and signing MAR charts prior to actually administering the medications.

In March 2020, it's alleged that Mrs Cantrell did not administer medication that was due to a resident and then subsequently recorded that it had been given when it had not. As a result of this, Mrs Cantrell was issued a first written warning.

In November 2021, it is alleged that Mrs Cantrell administered the wrong medication to a resident and subsequently recorded that the correct medication had been administered when it had not. It is also alleged that around the same time, Mrs Cantrell administered an antibiotic that was meant for one resident to another resident.

In January 2022, it's alleged that the registrant did not administer medication that was due to residents and subsequently recorded that the correct medication had been given. The medications that had not been administered were subsequently discovered unattended in pots on a drugs trolley.

The Home carried out a local investigation and a disciplinary hearing took place on 14 January 2022 whereby Mrs Cantrell was dismissed. She subsequently appealed her decision, but this was unsuccessful.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Marcelle-Brown on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Cantrell.

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: Registered Home Manager, Abbey View Care Home (at the time of the investigation of the incidents)

- Witness 2: Senior Nurse, Abbey View Care Home (at the time of the incidents)

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 the NMC.

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

Charge 1

1. On 24 August 2019 left medication for one or more of the following residents unattended on the drugs trolley;
    a. Resident A;
    b. Resident B;

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Witness 1, her written statement 1 dated 23 September 2022 and supplementary documentary evidence.

The panel took into account that Witness 1 stated:

"Mrs Cantrell had however recorded on the Medication Administration Record ("MAR") chart for Resident A that Resident A had refused the medication and that it was subsequently destroyed when it could not have been as it was found in a pot. For Resident B Mrs Cantrell had recorded on the MAR chart that they were asleep when they tried to administer medication, this alone does not amount to a drug error as Mrs Cantrell could attempt to administer the medication at a later point, however leaving the medication on the drug trolley when they had finished their shift and signed that the medication had been administered does amount to a medication error.

[…]

Following this incident, an investigation meeting was held between myself and Mrs Cantrell on 2 September 2019 in which Mrs Cantrell admitted they had left the medication in a pot with the residents."

The panel noted that this statement was produced more than three years after the alleged incident and that there were no associated care home records relating to these charges before it.

The panel had regard to the letter addressed to Mrs Cantrell dated 20 September 2019 from the Home which stated:

"It was reported that you have recently made a drug error on 24th August 2019 — Two pots of medication found in drug trolley labelled with resident names Resident A and Resident B mar chart for Resident A was recorded as refused and destroyed. Mar chart for Resident B is recorded as Asleep.

You have failed to follow the Standards for Medicines Management. Please refer to the attached NMC Standards to reacquaint your responsibilities and accountabilities as a nurse."[sic]

The panel noted that the evidence before it suggests that the medications were left inside the drugs trolley as opposed to 'on' the drugs trolley.

The panel took into account the evidence before it, but it was not satisfied that it has sufficient evidence before it to prove that the medications were left ‘on’ the drugs trolley and unattended. It therefore finds this charge not proved.

Charge 2

2. On 2 November 2019 did not give Resident B their medication which was due.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Witness 1, her written statement dated 23 September 2022 and supplementary documentary evidence.

Witness 1 stated:

> *“Mrs Cantrell made another medication error on 2 November 2019 in which they did not administer medication (I do not recall which medication) to Resident B at 22:00 and therefore there was a gap on the resident’s MAR chart. This was reported to me by another registered nurse (I do not recall who) who found the medication in a pot in the resident’s room. I understand that the Home have been unable to provide a copy of any associated documents such as any photographs of the medication, controlled drug book entries or MAR because the error was dealt with informally by the Home.”*

The panel had regard to the notes of the investigation interview dated 10 December 2019. The panel noted that the notes refer to a medication omission for Resident B and a gap in signature on 2 November 2019.

The panel had regard to the letter dated 1 January 2020 in which it stated:

“It was reported that you have recently made drug errors on:~

~ 2.11.19 Gap in signature and medication not given at 2200.”

The panel noted that did not have sight of the MAR chart for Resident B to determine that any medication was due and whether there was in fact a gap in signature for this medication round.

The panel took into account the evidence before it, but it was not satisfied that it has sufficient evidence before it to prove that the medication was not administered. The panel did not have evidence of any medical records or associated documentation to support this charge and therefore was not persuaded, on the balance of probabilities, that it is more likely than not that you did not give Resident B medication which was due. It therefore finds this charge not proved.

Charge 3

3. On 24 November 2019;
    a. Did not administer medication which was due to Resident D.
    b. Recorded that you had administered medication which was due to Resident D.

These charges are found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Witness 1, her written statement dated 23 September 2022 and supplementary documentary evidence.

Witness 1 stated;

“On 24 November 2019, Mrs Cantrell made another error in that they signed a MAR chart to confirm that medication (I do not recall what medication this was) had been

given to Resident […] at 06:00 but the medication was found in a pot by a Healthcare Assistant (HCA) (I do not recall their name) in the resident's room on the bedside table at 07:30 with the resident's name labelled and the medication inside. I was made aware of this by the HCA who reported this error to me. The Home did not conduct a formal investigation therefore, I understand that they have been unable to provide copies of the MAR charts or photographs associated with this incident."

The panel had regard to the notes of the investigation interview dated 10 December 2019. The notes state that Mrs Cantrell stated:

"6am. Late start 6.20am I [was] outside the resident room and potted the tablet. I put them on table left them […] I went to someone else – blood sugar. I just forgot it"[sic]

The panel noted that it did not have information before it to determine what the medication was, what time it was due or the MAR chart for the resident. The panel also took into account that reference to the identity of which resident this relates to has been redacted in the written statement of Witness 1.

In relation to the Investigatory Interview notes dated 10 December 2019, the panel found that this lacked clarity in respect of which resident and medication these charges related to.

The panel was not satisfied that it had sufficient evidence before it to prove that the medication was not administered, and that Mrs Cantrell recorded that the medication was administered when it was not. The panel therefore determined that this charge is found not proved.

Charge 4

4. Your actions at charge 3 were dishonest in that you sought to create the impression that you had administered the medication to Resident D when you knew you had not.

This charge is found NOT proved.

The panel determined that as it has found charge 3 not proved, as a result, charge 4 falls away.

Charge 5

5. On 5 March 2020 recorded that you had administered one or more of the following medications to Resident G when you had not.
    a. Pyridostigmine;
    b. Omeprazole.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Witness 1, her written statement, and supplementary documentation including the MAR chart for Resident G, the photographic evidence of the pot of medication for Resident G and the record of meeting dated 13 March 2020.

The panel had regard to the MAR chart for Resident G which indicates that Mrs Cantrell had documented that she had administered the medications to Resident G.

The panel noted that in the record of meeting dated 13 March 2020 it is recorded that Mrs Cantrell accepts having not administered a medication to Resident G. Mrs Cantrell explained that Resident G was having swallowing difficulties and that she had handed this over to another member of staff. It noted that Mrs Cantrell also stated:

"I was in a rush, […] I handed over to [Person 3] about not giving the tablet"

The panel had regard to the Disciplinary Meeting notes dated 23 March 2020 in which Mrs Cantrell also accepts having not administered a medication to Resident G.

The panel also had regard to the notification of the first written warning addressed to Mrs Cantrell dated 30 March 2020 which states:

> *"On the 5th March you had signed the MAR chart for these medications. The tablets were later found in the drug trolley, in a medicine pot, with the resident name on it. The Pyridostigmine was broken in quarters, some appeared to have been given, and the Omeprazole tablet was whole."*

Based on the evidence before it, the panel determined that, it is more likely than not, on the balance of probabilities that Mrs Cantrell recorded that she had administered one or more of the medications, as charged, to Resident G when she had not. The panel therefore finds this charge proved.

Charge 6

6. Your actions at charge 5 were dishonest in that you sought to create the impression that you had administered the medication when you knew you had not.

This charge is found NOT proved.

The panel considered that Mrs Cantrell did not attempt to conceal her error, she did not discard the medications and she explained that she informed other staff members that the medications had not been administered.

The panel noted that Mrs Cantrell provided a straightforward account of what occurred and has demonstrated acceptance of having not administered the medications.

The panel considered that it did not have information to suggest that the Home raised concerns regarding Mrs Cantrell's dishonesty as a result of the incidents.

The panel found that she did have a propensity to act in a way that was not good nursing practice, i.e. pre-potting medications and pre-signing MAR/eMAR charts but it did not determine that her actions were dishonest.

The panel was not satisfied that there is evidence to suggest that Mrs Cantrell's actions as set out in charge 5 were dishonest.

Charge 7

7. On the night shift of 5/6 November 2021;
    a. administered the wrong medication to Resident H
    b. Recorded that you had given resident H the correct medication which was incorrect.

These charges are found proved.

In reaching this decision, the panel took into account the oral evidence of Witness 1, her written statement and the supplementary documentary evidence.

In Witness 1's written statement she states:

> *"Mrs Cantrell made a medication error on 5 and 6 November 2021 during the early morning drug round in that they administered the wrong medication namely, Atorvastatin instead of Omeprazole to Resident H. This was reported by a Senior Carer to Mrs Cantrell who then handed over to the Senior Registered Nurse. The Senior Registered Nurse then reported this error to myself. […]*

Mrs Cantrell had taken the medication from the wrong box which was a similar colour to the correct box. Mrs Cantrell said that they thought they were administering Omeprazole but instead administered Atorvastatin which slows the production of cholesterol in the body. Mrs Cantrell confirmed this in their investigation interview which I discuss in paragraph 38 below. Mrs Cantrell signed the MAR charts to confirm the correct medication had been administered."

The panel had regard to Resident H's MAR chart. It noted that the MAR chart does not demonstrate that the incorrect medication was administered but does determine what medications Resident H was prescribed.

The panel also had regard to the two incident reporting forms which were completed by Mrs Cantrell.

The panel noted that Mrs Cantrell has made admissions to this incident having occurred at a local level. It noted that she informed Witness 1 that she had been stressed during the time that this occurred due to her own personal circumstances.

Based on the evidence before it, the panel determined that, it is more likely than not that on the night shift of 5/6 November 2021 Mrs Cantrell administered the wrong medication to Resident H and recorded that she had given resident H the correct medication which was incorrect.

Charge 8

8. On 29 November 2021 administered an antibiotic to Resident D which was meant for Resident I.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Witness 1, her written statement and supplementary documents including the local statement by Person 2.

Witness 1 stated:

> *"Another medication error was made by Mrs Cantrell on 29 November 2021 where they incorrectly administered an antibiotic to Resident D when this was meant for Resident I. Mrs Cantrell reported their medication error during the handover to the Senior Registered Nurse and this was then reported to myself. Following this error, a phone call was made by the Senior Carer to the GP on 30 November 2021 who visited the Home and confirmed this was unlikely to have a significant impact."*

The panel noted that Mrs Cantrell has made local admissions to this incident during a local meeting dated 14 December 2021. When asked to clarify how this error occurred, she stated:

> *"Find res. On EMAR, click was is due to be given. Take out of trolley & scan meds/box but I didn't […] I was making assumptions, taking time"*

The panel had regard to the written statement of Person 2 dated 3 December 2021. She stated:

> *"On Tuesday the 30th before handover start [Mrs Cantrell] stated to me […] that she had administered Doxycyclin capsules to Resident D instead of Resident I without checking the box or enter in the e-mar. She realised the med error after she saw Resident I's e-mar. She checked Resident D's vitals and observed during the night."*

Based on all the evidence before it, the panel determined that on the balance of probabilities, it is more likely than not that Mrs Cantrell administered an antibiotic to Resident D which was meant for Resident I. It therefore finds this charge proved.

Charge 9.1

9. On 5 January 2022;

   9.1 Left one or more of the following medications unattended on the medication trolley

   a. Co-Beneldopa
   b. Pregablin
   c. Simivastatin

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Witnesses 1 and 2, their witness statements and supplementary documents including the local statement of Person 1.

The panel had regard to Witness 2's written statement in which she stated:

> *"During a medication round, you would go round with the trolley moving up the floor as you administer medication then when this isn't being used it is kept in the Nurse's station which is a locked room and secured to the wall. I found medication on the trolley for the residents of rooms 26 and 28 respectively. Initially, I wasn't sure if this was medication that was pre-potted for the morning or whether it was from the night shift. […], a Senior Carer and I looked into this by checking the electronic system where the stock take is done and found that the medication had been taken out of stock by Mrs Cantrell yet hadn't been given to Resident E or*

Resident F. I took a photograph of the medication pots found which I attach a copy of as Exhibit [Witness 2]/2, and then reported this to the Clinical Lead.
[…]
Resident E's medication (room 26) was found on the medication trolley. There were two medications in the pot; namely one pill of Co-Beneldopa and one pill of Pregabalin.
Co-Beneldopa is a prescribed medication administered to people diagnosed with Parkinson's disease and controls the main symptoms (tremors and stiffness). Co-Beneldopa should be given five times a day."

However, the panel also had regard to Witness 1's contemporaneous note of the incident dated 6 January 2022 in which she stated:

"I found two pot […] medication & labelled inside door of trolley 2"

The panel noted Witness 1's written statement in which she stated:

"Another medication error by Mrs Cantrell was discovered by [Witness 2], Senior Nurse on the day shift of 6 January 2022. [Witness 2] found two pots labelled with medication inside in the drug trolley as shown in photographs taken a copy of which I attach as Exhibit [Witness 1]/28, these should have been administered to the residents by Mrs Cantrell on 5 January 2022."

The panel noted that both Witness 1's contemporaneous note and Witness 2's written statement described the medication pots being found inside the trolley as opposed to on. The panel determined that Witness 1's contemporaneous note is more reliable than her written statement dated 1 August 2022 as this was written over 6 months after the incident.

The panel therefore was not satisfied that there is sufficient evidence to determine that Mrs Cantrell left one or more of the named medications unattended on the medication trolley. It therefore found this charge not proved.

Charge 9.2

9.2 Did not administer one or more of the following medications to Resident E
   a. Co-Beneldopa;
   b. Pregablin.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Witness 2, her written statement and supplementary documentation including the photographic evidence and Witness 2's contemporaneous statement dated 6 January 2022. The panel also had regard to the statement of Person 1 dated 6 January 2022.

Witness 2's written statement states:

> "*Resident E's medication (room 26) was found on the medication trolley. There were two medications in the pot; namely one pill of Co-Beneldopa and one pill of Pregabalin."*

The panel had regard to the photographic evidence of Resident E's medication in the pot.

The panel also had regard to Person 1's contemporaneous statement dated 6 January 2022 which stated:

> *"Today after 10@10 [Witness 2] informed me, she noticed two pots of medication in trolley 2 - first floor. Both pots were labelled with resident room numbers. First pot*

was labelled with room 26 and we identified the tablets (Co-Beneldopa & Pregabalin)"

The panel found that the evidence before it was consistent and supported the charge as alleged.

The panel determined that, based on the evidence before it, it is more likely than not, that Mrs Cantrell did not administer one or more of the medications as set out in the charge to Resident E. It therefore finds this charge proved.

Charge 9.3

9.3 Recorded that you had given one or more of the medications specified at charge 9.2 to Resident E when you had not.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Witness 2, her written statement and supplementary documentation including the photographic evidence and Witness 2's contemporaneous statement dated 6 January 2022. The panel also had regard to the statement of Person 1 dated 6 January 2022.

The panel had regard to the documents for Resident E. This showed an entry on 5 January 2022 by Mrs Cantrell at 19:34 to show that the Co-Beneldopa and Pregabalin had been administered.

The panel had regard to the Investigation Interview notes dated 10 January 2022 in which Mrs Cantrell states:

"Took trolley of dispensed medication to pot: Resident E was asleep, kept for later […]
Signed for them

Didn't see the item in the morning
Pressure from personal problems was also disturbing her […]"

The panel also had regard to the Disciplinary Hearing notes dated 14 January 2022. Mrs Cantrell stated:

"Resident in Rm 28 usually asleep initially and then wakes up and spends a good deal of the night awake — his meds time was changed to 9pm previously. I come in at 7, get trollies ready. Start at one end of corridor, takes quite a long time. Lots of interruptions and answering bells, carers really busy. I started at room 25, no meds for 25 —the resident in 26 had been alert and eating and drinking so l took out her box, scanned meds, put dispersible one in separate pot to add water, I then scanned and ticked and signed as I was not far from the bedroom
[…]
Yes, I went into room she was fast asleep, she is a frail lady, I knew the carers would be going in for care later and she would be woken at that time so I thought I would go back then and so I put the meds into the shelf by the door. I had automatically signed and I know I am supposed to come back
— I just did it automatically."

The panel had regard to the handwritten local statement by Mrs Cantrell in which she stated:

"I was distracted and made oversights/errors on the night medication round on 5th January, resulting in 3 tablets not being given (2 residents involved) though I'd endeavoured to give them"

The panel determined that, based on the evidence before it, it is more likely than not, that Mrs Cantrell did record that she had given one or more of the medications specified at charge 9.2 to Resident E when she had not. It therefore finds this charge proved.

Charge 9.5

9.5 Did not administer Simvastatin to Resident F.

This charge is found proved.

In reaching its decision, the panel took into account the oral evidence of Witness 2, her written statement and supplementary documentation including the photographic evidence and Witness 2's contemporaneous statement dated 6 January 2022. The panel also had regard to the statement of Person 1 dated 6 January 2022.

The panel had regard to the photographic evidence of Resident F's medication in the pot.

The panel had regard to the Investigation Interview notes dated 10 January 2022 in which Mrs Cantrell states:

"Resident F was sleeping, kept for later"

The panel had regard to Witness 2's contemporaneous note of the incident dated 6 January 2022. She stated:

"Resident F and again identified as Simvastatin. This was signed as given last night shift by night nurse."

The panel determined that, based on the evidence before it, it is more likely than not, that Mrs Cantrell did not administer one or more of the medications as set out in the charge to Resident F. It therefore finds this charge proved.

Charge 9.6

9.6 Recorded that you had given Simvastatin to Resident F when you had not.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Witness 2, her written statement and supplementary documentation including the photographic evidence and Witness 2's contemporaneous statement dated 6 January 2022. The panel also had regard to the statement of Person 1 dated 6 January 2022.

The panel had regard to the Investigation Interview notes dated 10 January 2022 in which Mrs Cantrell states:

> *"For Resident F asked staff to let [Mrs Cantrell] know when he is awake and staff told [Mrs Cantrell] Resident F is awake, [Mrs Cantrell dispensed [medication] but Resident F was sleeping, kept for later*
> *Signed for them*
> *Didn't see the item in the morning*
> *Pressure from personal problems was also disturbing"*

The panel also had regard to the Disciplinary Hearing notes dated 14 January 2022. Mrs Cantrell stated:

> *"Resident in Rm 28 usually asleep initially and then wakes up and spends a good deal of the night awake — his meds time was changed to 9pm previously. I come in at 7, get trollies ready. Start at one end of corridor, takes quite a long time. Lots of interruptions and answering bells, carers really busy. I started at room 25, no meds for 25 —the resident in 26 had been alert and eating and drinking sol took out her box, scanned meds, put dispersible one in separate pot to add water, I then scanned and ticked and signed as I was not far from the bedroom*
> *[…]*
> *Yes, I went into room she was fast asleep, she is a frail lady, I knew the carers would be going in for care later and she would be woken at that time so I thought I*

would go back then and so I put the meds into the shelf by the door. I had automatically signed and I know I am supposed to come back — I just did it automatically."

The panel had regard to the handwritten local statement by Mrs Cantrell in which she stated:

"I was distracted and made oversights/errors on the night medication round on 5th January, resulting in 3 tablets not being given (2 residents involved) though I'd endeavoured to give them"

The panel determined that, based on the evidence before it, it is more likely than not, that Mrs Cantrell did record that she had given one or more of the medications specified at charge 9.2 to Resident F when she had not. It therefore finds this charge proved.

Charges 9.4 and 9.7

9.4 Your actions at charge 9.3 were dishonest in that you sought to create the impression that you had given Resident E one or more of the medications listed at charge 9.2 when you knew you had not.

9.7 Your actions at charge 9.6 were dishonest in that you sought to create the impression that you had given Resident F Simvastatin when you knew you had not

These charges are found NOT proved.

The panel considered that Mrs Cantrell did not attempt to conceal her error and that she did not discard the medications having not administered them. She gave clear explanations as to why she had not been able to administer the medications and explained why she had recorded that they were.

The panel noted that Mrs Cantrell provided a straightforward account of what occurred and has demonstrated acceptance of having not administered the medications.

The panel considered that it did not have information to suggest that the Home raised concerns regarding Mrs Cantrell's dishonesty as a result of the incidents.

The panel found that she did have a propensity to act in a way that was not good nursing practice, i.e. pre-potting medications and pre-signing MAR/eMAR charts but it did not determine that her actions were dishonest.

The panel was not satisfied that there is evidence to suggest that Mrs Cantrell's actions were dishonest.

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

Submissions on misconduct

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 had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Marcelle-Brown submitted that what amounts to misconduct is a matter for the panel's professional judgement, and there is no standard or burden of proof.

Ms Marcelle-Brown invited the panel to take the view that the facts found proved amount to misconduct. She identified the specific, relevant standards where Mrs Cantrell's actions fell short and amounted to misconduct.

Ms Marcelle-Brown submitted that the facts that have been found proved do amount to misconduct and that there are multiple breaches of the standards that were expected of Mrs Cantrell and that her actions demonstrate a departure from what would be proper in the circumstances.

Ms Marcelle-Brown submitted that the conduct in this case falls under the category of serious concerns which could result in patient harm if they are not put right. She referred to the NMC guidance which sets out:

> *"We wouldn't usually need to take regulatory action for isolated incidents of these failings unless the incident suggests that there may be an attitudinal issue such as*

displaying discriminatory views and behaviours. This may indicate a deep-seated problem even if there is only one reported incident. A pattern of incidents is usually more likely to show risk to patients or service users, requiring us to act."

Ms Marcelle-Brown submitted that this is a case where there were a number of incidents reported over a period of years. She invited the panel to take the view that this may be indicative of an attitudinal concern.

Ms Marcelle-Brown submitted that the facts found proved in this case are so serious that they should amount to a finding of misconduct as they are a serious falling short of what would be proper in the circumstances.

Submissions on impairment

Ms Marcelle-Brown moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Marcelle-Brown invited the panel to consider the NMC guidance on insight and strengthening practice. She also invited the panel to consider Mrs Cantrell's level of engagement in these proceedings as well as the local investigation stage.

Ms Marcelle-Brown submitted that it is for the registrant to show insight and remorse and remediation and to satisfy the panel that there is no risk of repetition. She submitted that in the absence of any such evidence, the panel could conclude that there remains a risk of repetition and therefore a finding of impairment should be made.

Ms Marcelle-Brown stated that Mrs Cantrell has not engaged with these proceedings, albeit in fairness to her, she was engaged at the very early stage when the referral was first made to the NMC and also, she engaged with the Home throughout the local investigations.

Ms Marcelle-Brown informed the panel that there is a suggestion that Mrs Cantrell completed a reflective piece in 2019 but that this was not available to the panel at this hearing. She submitted that in the absence of any reflective documentation, the panel is not assisted by knowing if Mrs Cantrell has sufficient insight into the concerns.

Ms Marcelle-Brown submitted that, based on the numerous records of meeting minutes, it appears Mrs Cantrell showed no insight into her actions during the local investigation and often deflected, rather than taking accountability for her actions even when it was clear that she had made an error.

Ms Marcelle-Brown submitted that Mrs Cantrell sought to minimise her actions and although it was her right to appeal the decision to dismiss her from the Home, she pointed out that Mrs Cantrell was of the view that this decision was disproportionate. She submitted that this demonstrates that Mrs Cantrell did not take into account the seriousness of her actions and that she did put the residents at serious risk of harm.

Ms Marcelle-Brown submitted that the panel may be of the view that there is an underlying problem with Mrs Cantrell's attitude in respect of her approach to medications management and record keeping. She reminded the panel that the concerns relate to numerous medication errors and record keeping errors which span over a significant period of time.

In fairness to Mrs Cantrell who is absent, Ms Marcelle-Brown referred the panel to the NMC guidance on context. She acknowledged that Mrs Cantrell raised contextual factors during the time of the incidents such as being busy on her shift or personal stressors. However, she reminded the panel that it has heard evidence that at the relevant time there

was nothing exceptional about the workload and that Mrs Cantrell did not raise any personal issues and that this only came to light at the disciplinary hearing.

Ms Marcelle-Brown submitted that whilst the panel should consider any contextual factors, it does not absolve Mrs Cantrell of her professional obligations or excuse her from not following the policy.

Ms Marcelle-Brown submitted that remediation is also a key consideration for the panel. She stated that Mrs Cantrell has not engaged with the NMC and that there is no evidence before the panel of any steps that have been taken by her to remediate the concerns that have been identified in the conduct found proved.

Ms Marcelle-Brown addressed the public confidence in the profession. She referred to the case of Grant which sets out that it is a fundamental consideration for the panel that there is a need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

In closing, Ms Marcelle-Brown submitted that, in light of there being no insight or remediation, there is a continued risk posed to the public and to patients if Mrs Cantrell were allowed to practice unrestricted. She submitted that in the absence of a finding of impairment, public confidence in the profession, as well as the regulator would be undermined as such conduct cannot be condoned. She stated that some level of intervention is necessary by way of a finding of impairment in order to protect the public and also to mark the public interest. She therefore invited the panel to make a finding of impairment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included reference to the cases of Cohen v GMC [2008] EWHC 581 (Admin) and Grant.

Decision and reasons on misconduct

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

The panel was of the view that Mrs Cantrell's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Cantrell's actions amounted to a breach of the Code. Specifically:

> ***"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.***
> *10.3 complete records accurately and without any falsification […]*
>
> ***18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
> *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***
> *20.1 keep to and uphold the standards and values set out in the Code"*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

However, the panel considered that there were numerous errors relating to the mismanagement of medication including failure to administer medications to residents,

administering incorrect medication and administering medication meant for one resident to another. The panel determined that this conduct put the residents in the care of Mrs Cantrell at a serious risk of harm although no actual harm was caused. The panel found that the concerns were raised locally with Mrs Cantrell in relation to her medications management and administration and despite these issues being raised to her and her undertaking reassessment in the relevant areas, the medication incidents continued to occur.

Further, the panel found that record keeping is a fundamental aspect of nursing and failure to keep accurate records directly impacts on the continuity of patient care. Record keeping is an integral part of the administration of medication and whilst there were no concerns raised as to Mrs Cantrell's overall general standard of record keeping, nonetheless in relation to the records involved in the administration of medication, the panel found her actions put residents at a real risk of harm and is sufficiently serious to amount to misconduct.

The panel found that Mrs Cantrell'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, Mrs Cantrell'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, 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 finds that residents were put at risk of harm as a result of Mrs Cantrell's misconduct. Mrs Cantrell's misconduct had breached the fundamental tenets of the nursing profession. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not take concerns that impact directly on patient care seriously.

Regarding insight, the panel considered that Mrs Cantrell made admissions to the incidents during the Home's local investigatory meetings. The panel also took into account that Mrs Cantrell explained that, at the time of the later incidents, she was under stress due to her family circumstances. The panel found that in Mrs Cantrell's statement dated 12 December 2021, she demonstrates genuine remorse for her errors and acceptance of her failures.

However, the panel did not have sight of any evidence of insight beyond this. The panel did not have evidence of any reflective accounts produced by Mrs Cantrell for these proceedings and it was not satisfied that she has demonstrated an understanding of how her actions put the residents in her care at a risk of harm. Mrs Cantrell has not demonstrated an understanding of why her actions were wrong and how this impacted negatively on the reputation of the nursing profession. The panel did not have any information before it which explains how Mrs Cantrell intends to handle the management, administration and accurate recording of administration of medication going forwards to ensure a repeat of her failures does not occur.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Cantrell has taken steps to strengthen her practice. The panel did not have evidence of any relevant training Mrs Cantrell has taken since these incidents to address the concerns.

In light of the lack of evidence of sufficient insight and steps taken by Mrs Cantrell to strengthen her practice, the panel determined that there is a risk of repetition. The panel

also noted that the concerns in this case do not relate to an isolated incident, and that Mrs Cantrell continued to have concerns raised due to her habitual processes even after they were addressed locally at the Home. The panel found that there is a real risk of continued harm to patients if she were allowed to practise as a nurse unrestricted given that she has not explained how she intends to strengthen her nursing practice.

For all of the reasons above, the panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 Mrs Cantrell's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Cantrell's 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 12 months. The effect of this order is that Mrs Cantrell's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her 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

The panel had regard to the Notice of Hearing in which the NMC had advised Mrs Cantrell that it would seek the imposition of a striking-off order if it found Mrs Cantrell's fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that a suspension order is more appropriate in light of the panel's findings.

Ms Marcelle-Brown invited the panel to consider the NMC guidance on sanctions which sets out the key considerations. She highlighted what she deemed to be aggravating and mitigating features in this case.

Ms Marcelle-Brown submitted that given the seriousness of the conduct in this case, the most suitable and appropriate sanction would be a suspension order with review.

Ms Marcelle-Brown submitted that taking no action would not be appropriate.
She submitted that, given the circumstances of this case, taking no action would not be in line with the overarching objective of public protection and it would not promote or maintain public confidence in the profession or the regulator.

Ms Marcelle-Brown submitted that, similarly with a caution order, given the concerns identified by the panel in its determination that there is a continued risk to patients, a caution order would not be appropriate in the circumstances.

Ms Marcelle-Brown moved onto a conditions of practice order. She referred to the SG and referred the panel to its findings in relation to misconduct and impairment. She stated that whilst there is some indication of attitudinal issues, these do not appear to be deep-seated or harmful. She submitted that there are identifiable areas of Mrs Cantrell's practice which

are in need of assessment or retraining and these are capable of being addressed. She submitted that there is no evidence of general incompetence.

However, Ms Marcelle-Brown submitted that Mrs Cantrell has disengaged with the process and there is no evidence before the panel to satisfy it that there is a potential and willingness to respond positively to retraining or that she would comply with any conditions if they were imposed. She therefore submitted that conditions of practice would not be adequate in addressing the concerns in this case.

Ms Marcelle-Brown submitted that a suspension order is the appropriate sanction in this case. She submitted that this is conduct which demonstrates a serious departure from what is expected of a registrant but is not conduct that is fundamentally incompatible with a registrant remaining on the register. She submitted that Mrs Cantrell did fall short of the conduct and standards expected of a nurse and it is clear that there was a serious departure. She submitted that the seriousness of the misconduct does require temporary removal from the register and that a period of suspension would adequately protect the public and maintain public confidence in the profession.

Decision and reasons on sanction

Having found Mrs Cantrell'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 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:

- Conduct which put patients at risk of suffering harm
- Repeated incidents relating to medications management and administration

- A pattern of misconduct over a period of time
- Lack of evidence of insight or remediation

The panel also took into account the following mitigating features:

- Admissions at early stages of the Home's local investigations
- Previous history in excess of 40 years of unblemished practice and good character
- No attempt to conceal or cover up the failures
- Personal and family circumstances which may have contributed to some of the later failings

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 Mrs Cantrell'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 Mrs Cantrell's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 Mrs Cantrell's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *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.*

Based on the factors above, the panel determined that a conditions of practice order would be workable and is proportionate to the seriousness of the concerns in this case. It determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel agreed with Ms Marcelle-Brown's submissions that Mrs Cantrell has disengaged with the process and there is no evidence before the panel to satisfy it that there is a potential and willingness to respond positively to retraining or that she would comply with any conditions if they were imposed. However, the panel was also of the view that there is no evidence that she would not comply with conditions of practice, given the opportunity.

The panel had regard to the fact that these incidents happened some time ago and that, other than these incidents, Mrs Cantrell has had a long and unblemished career as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Cantrell should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order would be disproportionate and would not be a reasonable response in the circumstances of this case. The panel agreed with the submissions made by Ms Marcelle-Brown that Mrs Cantrell's conduct

demonstrated a serious departure from the standards expected of a registrant. However, it was not in agreement that a period of suspension would be the only sanction that would adequately protect the public and maintain public confidence in the profession.

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 making this decision, the panel carefully considered the submissions of Ms Marcelle-Brown in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a conditions of practice order would provide the required level of public protection and meet the wider public interest as well as allowing Mrs Cantrell an opportunity to demonstrate she can return to safe nursing practice.

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 administer medications whilst directly supervised by another registered nurse. This must consist of:
    - Supervision whilst administering medications for a minimum of 12 shifts. The supervised medication rounds must be documented by you and signed off by the registered nurse.
    - You must not administer medications alone until you have undertaken a refresher course in the administration of

medication and successfully completed a clinical competency assessment in medications administration.

Upon successful completion of this competency assessment, you must provide evidence of this to your NMC case officer.

2. You must keep us 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.

3. You must keep us 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.

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

5. 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.

6. 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 12 months. The panel determined that this will give Mrs Cantrell sufficient time to re-engage with the NMC and demonstrate that she can return to safe nursing practice.

Before the order expires, a panel will hold a review hearing to see how well Mrs Cantrell has 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:

- Attendance at any future hearing of this case.
- If Mrs Cantrell has engaged with the conditions of practice order – a reflective piece detailing the impact and potential harm of Mrs Cantrell's medication errors on her patients, colleagues, the wider nursing profession and the public.
- If Mrs Cantrell has not engaged with the conditions of practice order – an indication from her as to what her future plans are in relation to her nursing practice.

This will be confirmed to Mrs Cantrell 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 Mrs Cantrell's 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 Ms Marcelle-Brown. She invited the panel to impose an 18-month interim conditions of practice order as it is necessary for the protection of the public and is otherwise in the public interest. She submitted that this was required to cover the 28-day appeal period and any period that an appeal may be lodged and heard. She submitted that the interim conditions of practice order should be the same as the substantive conditions of practice order.

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 the period of any appeal being lodged and heard.

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 Mrs Cantrell is sent the decision of this hearing in writing.

That concludes this determination.