Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 1 August – Tuesday, 8 August 2023

Virtual Hearing

Name of Registrant:	**Julie Fay**
NMC PIN	07H3091E
Part(s) of the register:	RNA: Adult nurse, level 1 (15 December 2007)
Relevant Location:	Westmorland and Furness
Type of case:	Misconduct
Panel members:	Jonathan Storey (Chair, Lay member) Kathryn Elizabeth Smith (Registrant member) Linda Redford (Lay member)
Legal Assessor:	Tracy Ayling KC (Day 1-4) Cyrus Katrak (Day 5-6)
Hearings Coordinator:	Sharmilla Nanan
Nursing and Midwifery Council:	Represented by Louise Cockburn, Case Presenter
Miss Fay:	Not present and not represented at the hearing
No case to answer (Rule 24(7)):	Charges 1a, 1b, 1c, 2a, 2b, 2c, 3a, 3b, 3c, 4a, 4b, 4c, 5b, 5c, 5d, 6a, 6b, 6c, 7a, 7b, 7c, 8a, 8b, 8c, 9a, 9b, 9c, 10 (only in relation to 08.35 and 12.25), 14, 15, 16 and 17.
Facts proved:	Charges 5a, 11, 12 and 13
Facts not proved:	Charges 9d and 10 (in relation to 16.40)
Fitness to practise:	Impaired

Sanction:	**Conditions of practice order (9 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 Miss Fay was not in attendance and that the Notice of Hearing letter had been sent to Miss Fay's registered email address by secure email on 3 July 2023.

Miss Cockburn, 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 Miss Fay'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 Miss Fay 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 Miss Fay

The panel next considered whether it should proceed in the absence of Miss Fay. It had regard to Rule 21 and heard the submissions of Miss Cockburn who invited the panel to continue in the absence of Miss Fay. She submitted that Miss Fay had voluntarily absented herself.

Miss Cockburn referred the panel to the email from Miss Fay dated 2 November 2022 which stated:

"Hi I have contacted the NMC before that I will not be attending or responding to any hearings etc etc.. I have said that I want to remove myself from the register [PRIVATE]. I have found a career that I enjoy [PRIVATE].

I need to put all this behind me and concentrate on myself. [PRIVATE]."

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 Miss Fay. In reaching this decision, the panel has considered the submissions of Ms Cockburn, the email sent by Miss Fay, 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] EWCA Civ 162 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 Miss Fay;
- Miss Fay has informed the NMC that she will not be attending any hearings;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness is in attendance today to give live evidence;
- Not proceeding may inconvenience the witness, her employer and, as she is involved in clinical practice, the clients who need her professional services;
- The charges relate to events that occurred in 2018 and 2019;
- Further delay may have an adverse effect on the ability of witness to accurately recall events; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Fay in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC 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 Miss Fay's decisions 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.

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

Details of charge

That you a registered nurse:

1. On 19 June 2019 in relation to Patient B failed to;
   (a) Have someone witness the disposal of the medication.
   (b) Obtain a second signature to confirm that the medication had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication was disposed.

2. On 26 June 2019 in relation to Patient C failed to;
   (a) Have someone witness the disposal of the medication.
   (b) Obtain a second signature to confirm that the medication had been correctly disposed of.

(c) Record on Lorenzo the reasons why the medication was disposed.

3. On 31 July 2019 in relation to Patient D failed to;
   (a) Have someone witness the disposal of the medication.
   (b) Obtain a second signature to confirm that the medication had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication was disposed.

4. On 9 July 2019 in relation to Patient E failed to;
   (a) Have someone witness the disposal of the medication.
   (b) Obtain a second signature to confirm that the medication had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication was disposed.

5. On 10 August 2019 in relation to Patient F failed to;
   (a) Record a time in the controlled drugs book that the medication was dispensed by accident and destroyed.
   (b) Have someone witness the disposal of the medication.
   (c) Obtain a second signature to confirm that the medication had been correctly disposed of.
   (d) Record on Lorenzo the reasons why the medication was disposed.

6. On 12 August 2019 in relation to Patient F failed to;
   (a) Have someone witness the disposal of the medication.
   (b) Obtain a second signature to confirm that the medication had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication was disposed.

7. On 19 August 2019 in relation to Patient F failed to;
   (a) Have someone witness the disposal of the medication.

(b) Obtain a second signature to confirm that the medication had been correctly disposed of.
(c) Record on Lorenzo the reasons why the medication was disposed.

8. On 20 August 2019 in relation to Patient F failed to;
(a) Have someone witness the disposal of the medication.
(b) Obtain a second signature to confirm that the medication had been correctly disposed of.
(c) Record on Lorenzo the reasons why the medication was disposed.

9. On 19 August 2019 in relation to Patient G failed to;
(a) Have someone witness the disposal of the medication.
(b) Obtain a second signature to confirm that the medication had been correctly disposed of.
(c) Record on Lorenzo the reasons why the medication was disposed.
(d) Record the disposal of the medication in the correct controlled drugs book, having recorded it in the 30mg codeine controlled drugs book.

10. On 12 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient H at 08.35 and/or 12.25 and/or 16.40.

11. On 19 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient G at 12.30.

12. On 20 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient G at 12.40.

13. On 21 August 2019 incorrectly entered in the controlled drugs book that you had administered 15mg of Codeine to Patient G when Patient G had been discharged on 20 August 2019.

14. On 14 October 2019 failed to record on Lorenzo the reasons why you had administered 5mls of Codeine Linctus to Patient I at 08.50 and/or 12.35 via syringe.

15. On 25 April 2018 incorrectly entered in the controlled drugs book that you had administered 30mg of Codeine to Patient J at 16.30 when they had been discharged from the hospital at 12.27.

16. On 10 July 2019 incorrectly entered in the controlled drugs book that you had administered 300mg of Gabapentin to Patient K at 12.05 when they had been discharge from the hospital at 09.49.

17. On 12 February 2018 incorrectly entered in the controlled drugs book that you had administered 30mg of Codeine to Patient L at 11.00 and/or 19.20 when it had been recorded that they were deceased at 09.30.

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

Background

Miss Fay began working as a registered nurse for the University Hospitals of Morecambe Bay NHS Trust (the Trust) in 2016. She initially worked in the outpatients department of Westmorland General Hospital and transferred to Ward six of the Furness General Hospital in November 2017.

In September 2019, there was an audit and review of the usage of medications, including controlled drugs. The review found a number of discrepancies in Miss Fay's work and she was suspended from the Trust on 17 October 2019. A disciplinary hearing was held in June 2020, and Miss Fay was subsequently dismissed from her role at the Trust on 25 June 2020.

A referral to the NMC was submitted on 30 July 2020. The concerns related to poor medication practice in relation to controlled drug procedures and the management of

medication, including administration and disposal, and poor record keeping in which it was alleged that Miss Fay entered inaccurate records.

Miss Fay has not fully engaged with the NMC, [PRIVATE].

The NMC will call Witness 1 who will provide evidence in relation to the nine allegations of when Miss Fay failed to have someone witness the disposal of medication, obtain a second signature for that disposal and record on the computerised notes the reason for the disposal of the medication. Witness 1 will also provide evidence that Miss Fay failed to record the administration of medication, and/or that she inaccurately recorded the administration of medication on a further eight occasions.

Decision and reasons on application to amend the charge

After the evidence of Witness 1, the panel heard an application made by Ms Cockburn, on behalf of the NMC, to amend the wording of charges 5a, 9d, 13, 15 and 16.

The proposed amendment was to change the wording of the charges. It was submitted by Ms Cockburn that the proposed amendments would provide clarity and more accurately reflect the evidence.

Proposed changes to the wording of the charges:

"5. On 10 August 2019 in relation to Patient F failed to;
(a) Record a time in the ~~controlled drugs~~ ***medication*** *book that the medication was dispensed by accident and destroyed."*

…

9. On 19 August 2019 in relation to Patient G failed to;
…

*(d) Record the disposal of the medication in the correct ~~controlled drugs~~ **medication** book, having recorded it in the 30mg codeine controlled drugs book.*

…

*13. On 21 August 2019 incorrectly entered in the ~~controlled drugs~~ **medication** book that you had administered 15mg of Codeine to Patient G when Patient G had been discharged on 20 August 2019.*

…

*15. On 25 April 2018 incorrectly entered in the ~~controlled drugs~~ **medication** book that you had administered 30mg of Codeine to Patient J at 16.30 when they had been discharged from the hospital at 12.27.*

*16. On 10 July 2019 incorrectly entered in the ~~controlled drugs~~ **enhanced drugs** book that you had administered 300mg of Gabapentin to Patient K at 12.05 when they had been discharge from the hospital at 09.49."*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel determined that it was in the interests of justice to amend the allegations but decided to reject the specific amendments proposed by Ms Cockburn on behalf of the NMC. The panel determined that the use of *'enhanced drug book'* in charges 5a, 9d, 13, 15, 16 and 17 more accurately reflected the evidence of Witness 1. In addition, the panel was of the view that the actual medications as they related to each individual patient should be reflected in each charge so that an individual reading the charges would be clear as to what the allegations were against Miss Fay. The panel was satisfied that there would be no prejudice to Miss Fay and no injustice would be caused to either party by its

amendments. The panel determined that it was therefore appropriate to make the amendments which follow to ensure clarity and accuracy of the charges.

Details of charge (as amended)

That you a registered nurse:

1. On 19 June 2019 in relation to Patient B failed to;
   (a) Have someone witness the disposal of medication*
   (b) Obtain a second signature to confirm that the medication * had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication* was disposed of.

2. On 26 June 2019 in relation to Patient C failed to;
   (a) Have someone witness the disposal of the medication*
   (b) Obtain a second signature to confirm that the medication* had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication was disposed of

3. On 31 July 2019 in relation to Patient D failed to;
   (a) Have someone witness the disposal of the medication*
   (b) Obtain a second signature to confirm that the medication* had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication* was disposed of

4. On 9 July 2019 in relation to Patient E failed to;
   (a) Have someone witness the disposal of the medication*.
   (b) Obtain a second signature to confirm that the medication * had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication* was disposed of

5. On 10 August 2019 in relation to Patient F failed to;
   (a) Record a time in the enhanced drugs book that the medication * was dispensed by accident and destroyed.
   (b) Have someone witness the disposal of the medication*.
   (c) Obtain a second signature to confirm that the medication* had been correctly disposed of.
   (d) Record on Lorenzo the reasons why the medication* was disposed of

6. On 12 August 2019 in relation to Patient F failed to;
   (a) Have someone witness the disposal of the medication*.
   (b) Obtain a second signature to confirm that the medication* had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication* was disposed of

7. On 19 August 2019 in relation to Patient F failed to;
   (a) Have someone witness the disposal of the medication*.
   (b) Obtain a second signature to confirm that the medication * had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication* was disposed of

8. On 20 August 2019 in relation to Patient F failed to;
   (a) Have someone witness the disposal of the medication*.
   (b) Obtain a second signature to confirm that the medication* had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication * was disposed of

9. On 19 August 2019 in relation to Patient G failed to;
   (a) Have someone witness the disposal of the medication*
   (b) Obtain a second signature to confirm that the medication * had been correctly disposed of.
   (c) Record on Lorenzo the reasons why the medication* was disposed of

(d) Record the disposal of the medication in the correct enhanced drugs book, having recorded it in the 30mg codeine enhanced drugs book.

10. On 12 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient H at 08.35 and/or 12.25 and/or 16.40.

11. On 19 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient G at 12.30.

12. On 20 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient G at 12.40.

13. On 21 August 2019 incorrectly entered in the enhanced drugs book that you had administered 15mg of Codeine to Patient G when Patient G had been discharged on 20 August 2019.

14. On 14 October 2019 failed to record on Lorenzo the reasons why you had administered 5mls of Codeine Linctus to Patient I at 08.50 and/or 12.35 via syringe.

15. On 25 April 2018 incorrectly entered in the enhanced drugs book that you had administered 30mg of Codeine to Patient J at 16.30 when they had been discharged from the hospital at 12.27.

16. On 10 July 2019 incorrectly entered in the enhanced drugs book that you had administered 300mg of Gabapentin to Patient K at 12.05 when they had been discharged from the hospital at 09.49.

17. On 12 February 2018 incorrectly entered in the enhanced drugs book that you had administered 30mg of Codeine to Patient L at 11.00 and/or 19.20 when it had been recorded that they were deceased at 09.30.

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

Schedule 1:

Reference to medication* in charges above relates to the following medication:

CHARGE	PATIENT	MEDICATION
1. 19 June 2019	B	Codeine 30mg tabs
2. 26 June 2019	C	Codeine 15mg tabs
3. 31 July 2019	D	Codeine 30mg tabs
4. 9 July 2019	E	Diazepam 5mg tabs
5. 10 August 2019	F	Tramadol 50mg tabs
6. 12 August 2019	F	Tramadol 50mg tabs
7. 19 August 2019	F	Tramadol 50mg tabs
8. 20 August 2019	F	Tramadol 50mg tabs
9. 19 August 2019	G	Codeine 15mg tabs

Decision and reasons on application of no case to answer

Under Rule 24(7), the panel invited Ms Cockburn to make submissions as to whether Miss Fay has a case to answer in respect of the charges.

Ms Cockburn referred the panel to the NMC guidance on Evidence, reference DMA-6, dated 1 July 2022, 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and the judgment in the case of *R v Galbraith* [1981] 1 WLR 1039. She submitted that it is the NMC's view that there is little meaningful difference between 'not doing something' and 'failing to do something'. She further submitted that the "duty to do something" could also be inferred from the Code and the obligations imposed on nurses in their everyday nursing practice. She submitted that this was the basis upon which the charges were originally drafted. She further submitted, that the assessment of whether there is a duty might be more properly assessed at the misconduct and impairment stage of these proceedings.

Ms Cockburn submitted that there is a case to answer in respect of all the charges. She referred the panel to the NMC's evidence matrix which had been provided to the panel which describes the evidence which supports each of the charges. She submitted that the charges have been drafted in light of Witness 1's NMC statements and the documents she exhibited. She noted that Witness 1 confirmed that her evidence remained true to the best of her knowledge and belief at the beginning of her oral evidence.

The panel took account of the submissions made and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it. At this stage, the panel was solely considering whether sufficient evidence had been presented such that it could find the facts proved, and therefore whether Miss Fay had a case to answer.

Before turning to the individual charges, the panel noted Witness 1's evidence that at the relevant time all the medications listed in the schedule above were enhanced drugs. It then considered whether the NMC had adduced evidence that there was a duty on Miss Fay, in relation to enhanced drugs, to (a) have someone witness the disposal of such medication, (b) obtain a second signature to confirm that it had been correctly disposed of,

and (c) record on Lorenzo the reasons why such medication had been disposed of. It could find no evidence in any written form that such a duty existed. No policy document had been put before the panel to describe such a duty.

Miss Fay stated in a Trust interview that she had not been informed that she was under a duty to do any of these things. It noted Witness 1's oral evidence that it was "good practice" to (a) have someone witness the disposal of the medication, (b) obtain a second signature and (c) record the reasons on Lorenzo, as it had been mentioned in ward meetings and the communications book. The panel decided that this evidence was vague and that there was no further evidence before it to support Witness 1's position. Indeed, the panel noted Witness 1's other oral evidence that the signing by a witness was "not essential", and noted that Witness 1 said of her nursing colleagues on the ward that *"maybe some of them didn't acknowledge it was good practice"*. The panel also took into consideration that Witness 1 accepted that medications had moved in and out of enhanced status.

The panel therefore found that there was no evidence, either oral or documentary, to support the existence of a duty on Miss Fay to (a) have someone witness the disposal of such medication, (b) obtain a second signature to confirm that it had been correctly disposed of, and (c) record on Lorenzo the reasons why such medication had been disposed of.

Charge 1 (in its entirety), 2 (in its entirety), 3 (in its entirety), 4 (in its entirety)

The panel had regard to its reasoning outlined above that the NMC had adduced no evidence that there was a duty on Miss Fay, in relation to enhanced drugs, to (a) have someone witness the disposal of such medication, (b) obtain a second signature to confirm that it had been correctly disposed of, and (c) record on Lorenzo the reasons why such medication had been disposed of.

The panel therefore found that there was no case to answer in respect of these charges.

Charge 5a

The panel noted that the charge alleged that on 10 August 2019, Miss Fay failed to record a time in the enhanced drugs book that the medication in question was dispensed by accident and destroyed. The panel bore in mind that it had a relevant extract from the enhanced drugs book and accepted that there was a duty on Miss Fay to record within it the time that the medication was dispensed by accident and destroyed. There was a column in the book where the time was required to be entered. The panel therefore determined that there was a case to answer in respect of this charge.

Charges 5b, 5c, 5d, 6 (in its entirety), 7 (in its entirety), 8 (in its entirety) and charges 9a, 9b, 9c

The panel had regard to its reasoning outlined above that the NMC had adduced no evidence that there was a duty on Miss Fay, in relation to enhanced drugs, to (a) have someone witness the disposal of such medication, (b) obtain a second signature to confirm that it had been correctly disposed of, and (c) record on Lorenzo the reasons why such medication had been disposed of.

The panel therefore found that there was no case to answer in respect of these charges.

Charge 9d

The panel noted the charge that, on 19 August 2019, Miss Fay failed to record the disposal of 15 mg of Codeine in the correct enhanced drugs book. The panel took into consideration that it had an extract from the Codeine 30mg enhanced drugs book in which it appeared that Miss Fay had recorded the disposal of 15mg of Codeine. The panel therefore determined that there was some evidence in support of this charge and that there was a case to answer in respect of charge 9d.

Charges 10, 11, 12

The panel took into consideration that charge 10 related to entries that Miss Fay had allegedly failed to record on Lorenzo on 12 August 2019 in respect of Patient H that she had administered 5mg of Codeine to Patient H at 08.35 and/or 12.25 and/or 16.40. The panel noted that it had the relevant Lorenzo records for Patient H and that there were entries made at 8.40 and 12.28 on 12 August 2019. The panel decided that these entries were close to the times outlined in the charge namely 08.35 and 12.25, and so found that there was no case to answer in respect of these times in the charge. However, the panel noted that it had no evidence before it in respect of an entry for 16.40 on 12 August 2019 to support that Miss Fay had administered 5mg of Codeine to Patient H. It therefore determined that there was only a case to answer in respect of the 16.40 timing specified in charge 10.

It took into consideration that charge 11 related to an entry that Miss Fay had allegedly failed to record on Lorenzo on 19 August 2019 for Patient G and that charge 12 related to an entry that Miss Fay had allegedly failed to record on Lorenzo on 19 August 2019 for Patient G. The panel noted that although it had evidence from the enhanced drugs books that the medication to which charges 11 and 12 had been dispensed, it had no corresponding record on Lorenzo within the evidence produced in relation to this charge and therefore determined that there was a case to answer in respect of these charges.

Charge 13

The panel noted that it had Patient G's related medical notes and the formal discharge summary for Patient G. The panel was of the view that that on the face of the evidence before it, there was a case to answer in respect of this charge.

Charge 14

In respect of this charge, the panel noted the evidence of Witness 1 that Miss Fay had *"dispensed 5 mls in an oral syringe"* to Patient I. It further noted that Witness 1 stated that Patient I *"could eat and drink normally and you would only use lintus[sic] if a patient had a NG or Peg tube. There is no documentation on the Lorenzo notes to state why lintus[sic] was used which you would need if you were administering this medication to a patient who was not peg or NG fed."*

The panel also had regard to the Codeine Linctus 15mg/5mls drug record and the respective entries made for Patient I on 14 October 2019. The drug record did not record the route by which the codeine linctus had been administered to Patient I.

The panel could find no evidence in support of a duty on Miss Fay to record on Lorenzo the route of administration and the reasons for doing so. It was, furthermore, at a loss to find any evidence beyond Witness 1's assertion that Miss Fay had in fact used a syringe as alleged in the charge.

In light of the above reasons, the panel determined that there was no case to answer in relation to charge 14.

Charges 15, 16, 17

The panel considered charges 15, 16 and 17 together. It took into consideration that these charges related to entries that Miss Fay had allegedly made incorrectly in the enhanced drugs books on 25 April 2018, 10 July 2019 and 12 February 2018 in respect of Patient J, Patient K and Patient L respectively.

The panel had regard to the extract from the Codeine 15mg tablets enhanced drugs book exhibited by Witness 1. The panel took into consideration that the patients on this extract had been redacted and were not identifiable. The panel bore in mind that there was a highlighted entry on '25/4/2018' at 16.30 and to the left of this entry there was a highlighted handwritten note stating, 'Discharge date 25/4/2018 Time 12:27'. There was no information as to who made this entry regarding the discharge and Witness 1 could not

assist the panel with this. The panel concluded that this handwritten note on the enhanced drugs book suggested that a patient was discharged on that date. It was however impossible to conclude that it was Patient J who had been discharged at the time alleged. The panel also noted that it did not have any formal discharge information for Patient J.

The panel considered the extract from the enhanced drugs book exhibited by Witness 1, in relation to which it is alleged that Miss Fay on 10 July 2019 incorrectly entered that she had administered 300mg of Gabapentin to Patient K at 12.05 when they had been discharged from the hospital at 09.49. The panel took into consideration that the patients on this extract were redacted and were not identifiable. The panel bore in mind the highlighted entry on '10/7/2019' at '12:05', to the left of which there was a handwritten note which stated *"+ time made of discharge".* The panel concluded that this handwritten note on the enhanced drugs book suggested that a patient was discharged on that date. It was however impossible to conclude that it was Patient K who had been discharged at the time alleged. The panel also noted that it did not have any formal discharge information for Patient K.

The panel considered the extract from the Codeine 30mg tablets enhanced drugs book exhibited by Witness 1. The panel took into consideration that the patients on this extract had been redacted and were not identifiable. The panel bore in mind the highlighted entries on '12/2/2018' at '19:00' and '19:20'. It noted that it had no other documentary evidence which support Witness 1's NMC statement that *"At the time it was identified that Patient L had been passed away at 09.30 on 12 February 2018 prior to the administration."*

The panel found that the evidence in respect of these charges was unsatisfactory, weak and tenuous, and insufficient for any panel to find these charges proved. The panel therefore determined that there was no case to answer in relation to these charges.

In conclusion, the panel decided that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charges 1a, 1b, 1c, 2a, 2b, 2c,

3a, 3b, 3c, 4a, 4b, 4c, 5b, 5c, 5d, 6a, 6b, 6c, 7a, 7b, 7c, 8a, 8b, 8c, 9a, 9b, 9c, 10 (only in relation to 08.35 and 12.25), 14, 15, 16 and 17 proved.

The panel determined that there is some evidence to support charges 5a, 9d, 10 (in relation to 16.40 only), 11, 12 and 13. As such, it was prepared, based on the evidence before it, to accede to the NMC submissions and find a case to answer in respect of these charges. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Miss Fay.

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 witness called on behalf of the NMC:

- Witness 1: At the material time was employed at The Trust as a Ward Manager. She had a professional relationship with Miss Fay and shared supervision of her with her colleagues.

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 disputed charges and made the following findings.

Charge 5a

> "On 10 August 2019 in relation to Patient F failed to;
> (a) Record a time in the enhanced drugs book that the medication* was dispensed by accident and destroyed."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel considered the extract from the enhanced drugs book which documented the entries for the administration of medication for Patient F on 10 August 2019. The panel noted that the enhanced drugs book had a column for the time to be recorded of when the medication was dispensed to the patient and considered that there was a duty on the person completing the entry to record the time, even if the medication had been dispensed by accident. The panel took into account that the extract from the book did not record a time for the entry of the medication that had been dispensed by accident on the 10 August 2019. The entry had Miss Fay's stamp and signature which suggested that she made this entry.

The panel noted the redactions of this extract and that there was a possibility there was further information underneath the entry which may have assisted it. However, on the balance of probabilities the panel found that Miss Fay had a duty to record the time the medication was dispensed by accident on the enhanced drug record but did not do so. It therefore found this charge proved.

Charge 9d

> "On 19 August 2019 in relation to Patient G failed to;
> (d) Record the disposal of the medication in the correct enhanced drugs book, having recorded it in the 30mg codeine enhanced drugs book."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel had regard to Witness 1's NMC statement which states *"Julie records that the 15mg codeine should be discarded as it was dispensed in error. This is recorded in the wrong drug book as this is the drug book that relates to 30mg codeine. Again the stock balance is correct but there is no witnesses or second signature. I also produce … a copy of Patient G's patient notes. This confirms that Julie had not recorded anything in Patient G's patient notes to support that any medication was dispensed in error."*

The panel took into consideration the extract from the Codeine 30mg enhanced drugs book in which it appeared that Miss Fay had recorded the disposal of 15mg of Codeine. The panel noted that there was a line through the entry which may suggest that Miss Fay realised her error. However, the panel did not have an extract from the Codeine 15mg enhanced drug book and so could not ascertain if this disposal was subsequently recorded in the correct enhanced drugs book. It therefore found this charge not proved.

Charge 10

> "On 12 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient H at 08.35 and/or 12.25 and/or 16.40*."
>
> **Only in respect of 16.40*

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel had an extract from the enhanced drugs book for Codeine Phosphate 15mg tablets and noted that Miss Fay signed the medication out at 16.40 for Patient H. It took into consideration Witness 1's oral evidence that Miss Fay did not make a corresponding entry in the Lorenzo system but noted that no screenshot from Lorenzo had been adduced at or around the same time. The panel bore in mind Witness 1's oral evidence that she did not believe that Miss Fay had made such an entry. Witness 1 thought she had submitted the relevant documentation to that effect but accepted in her oral evidence that she may have made an error. The panel was therefore not satisfied that the NMC had discharged its burden of proof to find this charge proved.

Charge 11

> "On 19 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient G at 12.30."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel considered the relevant entries in the enhanced drugs book and Lorenzo screenshots. It noted that the enhanced drugs book included an entry on 19 August 2019 at 12.30 to indicate that Miss Fay had signed this drug out for Patient G. The panel noted that the entry on Lorenzo showed that the patient's dose was due on *"20-Aug-2019 12:00"* but was recorded on *"20-Aug-2019 15:23"*.

The panel had regard to Witness 1's NMC statement which states *"You can see on the notes that Julie's name is not entered to say she had recorded anything after the first*

administration at 08.48 on 19 August 2019. The system has then logged itself out. You cannot take this as an electronic signatures as she has not gone into the notes to sign for the medication despite recording the medication has been given in the enhanced drug book." The panel took into consideration that this Lorenzo screenshot did not show that this medication was administered by Miss Fay.

The panel considered the evidence before it. It was apparent that Miss Fay signed out 15mg of Codeine from the enhanced drugs book on 19 August 2019 at 12.30 but that she had not made a corresponding entry in Lorenzo which the panel considered was her duty. The panel therefore found this charge proved.

Charge 12

> "On 20 August 2019 failed to record on Lorenzo that you had administered 15mg of Codeine to Patient G at 12.40."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence outlined at charge 11 and the evidence of Witness 1.

The panel considered Patient G's the relevant entries in the enhanced drugs book and Lorenzo screenshots. It noted that the enhanced drugs book included an entry on 20 August 2019 at 12.40 to indicate that Miss Fay had signed this drug out for Patient G. The panel noted that the entry on Lorenzo was due on *"20-Aug-2019 12:00"* but was recorded on *"20-Aug-2019 15:23"*.

The panel considered the evidence before it. It was apparent that Miss Fay signed out 15mg of Codeine from the enhanced drugs book on 20 August 2019 at 12.40 but that she had not made a corresponding entry in Lorenzo which was her duty. The panel therefore found this charge proved.

Charge 13

> "On 21 August 2019 incorrectly entered in the enhanced drugs book that you had administered 15mg of Codeine to Patient G when Patient G had been discharged on 20 August 2019."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted that the enhanced drugs book for the Codeine Phosphate 15mg Tablets included an entry on 21 August 2019 at 12.49 to indicate that Miss Fay had signed this drug out for Patient G.

The panel considered the discharge summary and checklist for Patient G which was created on the previous day, 20 August 2019 at 15:15 by Witness 1. It noted that it said within the discharge summary documentation *"discharged home today with [redacted] feom [sic] taking patient home…"*

The panel took into account the evidence before it and considered on the balance of probabilities that Miss Fay had signed out the drug for Patient G after he had been discharged from the hospital. The panel therefore found this charge 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 Miss Fay's fitness to practise is currently impaired. There is no statutory definition of fitness to practise but the NMC's guidance on impairment, reference DMA-1, dated 27 March 2023, states *"The question that will help decide whether a professional's fitness to practise is*

impaired is: "Can the nurse, midwife or nursing associate practise kindly, safely and professionally?" If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired."

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

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

Submissions on misconduct

Ms Cockburn referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Cockburn invited the panel to take the view that the facts found proved amount to misconduct. She identified a number of paragraphs within the Code which the NMC said that Miss Fay's conduct had breached. She submitted that the concerns regarding Miss Fay's practice are serious and referred to the reasons Miss Fay provided locally as to why the errors were made. Ms Cockburn submitted that the Trust had put in place support for Miss Fay and that Miss Fay had not raised any concerns with her manager. Further, Ms Cockburn submitted that Miss Fay's conduct has established a pattern of errors in relation to her obligation to practise safely with regard to the administration of medication.

Submissions on impairment

Ms Cockburn 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. In her submissions Ms Cockburn referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) *and Cohen v GMC* [2008] EWHC 581 (Admin) and to the NMC's guidance on Impairment.

Ms Cockburn submitted that, by failing to ensure up-to-date and accurate records, Miss Fay has put the health, safety and well-being of the public at risk. She submitted that a reasonable and well-informed member of the public would be shocked to hear of the shortcomings in Miss Fay's nursing practice. She also submitted that a breach of the Code is taken to be a breach of the fundamental tenets of nursing practice.

Ms Cockburn addressed the panel on whether Miss Fay had remediated her conduct. She noted that Miss Fay's conduct could be remediated but it had not been and that it was likely to be repeated. She submitted that Miss Fay lacked insight and sought to lay the responsibility for her mistakes on the Trust. She submitted that Miss Fay has not shown any remorse and has not explained how her actions put patients' safety at risk or how they affected her colleagues. She informed the panel that Miss Fay has not practised as a nurse since she was suspended from working at the Trust on 17 October 2019. She submitted that Miss Fay has not provided any evidence of training to ensure that her practice is safe and effective.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin) and *Schodlok v. GMC* [2015] EWCA Civ 769.

Decision and reasons on misconduct

The panel considered each of the charges in turn as to whether the facts found proved amount to misconduct. In respect of Charge 5a, the panel noted that no time recording had been made of when the medication had been dispensed by accident although the other information that had been recorded was quite clear. The panel noted that there was no risk to any patient as the medication had been destroyed. It therefore determined that the fact found proved in this charge by itself did not cross the threshold for serious misconduct.

The panel considered charges 11 and 12 together. The panel took into consideration that, during a meeting held with the Trust on 4 February 2020, Miss Fay said that she *'sometimes had an issue with the computers on the ward… it is sometimes difficult to record it on Lorenzo as someone else is using the computer then it goes out of your head as it has been signed for in the book…'* The panel noted that, by not making the appropriate entries in Lorenzo, patients were put at risk as other nurses may not have known that the medication had been given. The panel therefore determined that Miss Fay's actions in these charges amounted to serious misconduct.

The panel considered charge 13. It noted that Miss Fay signed out medication on the enhanced drugs book for a patient who had been discharged from the hospital the previous day. The panel was unclear as to what happened to the medication but that it was likely that there was no risk of patient harm in this instance. The panel determined that this charge did not amount to serious misconduct on its own.

The panel also considered the charges cumulatively and determined that Miss Fay's actions in the charges demonstrated a pattern of conduct in which she lacked care and attention in respect of the recording of the administration of medication. The panel determined that, although it had not found serious misconduct in relation to charges 5a and 13, it decided that together with charges 11 and 12 they formed a pattern of poor practice that amounted cumulatively to serious 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 Miss Fay's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Fay's actions amounted to a breach of the Code. Specifically:

'10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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

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

To achieve this, you must:

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

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 Miss Fay'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, Miss Fay'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. 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 patients were put at risk of harm as a result of Miss Fay's misconduct in respect of charges 11 and 12 but noted that no harm to patients had been reported. Miss Fay's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel had regard to the question of whether Miss Fay could *"practise kindly, safely and professionally?"*

It first considered Miss Fay's insight and that she had not demonstrated an understanding of how her actions put patients at a risk of harm and has not demonstrated an understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. She has not apologised for her failings or demonstrated how she would handle the situation differently in the future. The panel noted that Miss Fay, during the Trust's investigation, sought to blame the Trust for her failings. The panel determined that Miss Fay had no insight.

The panel bore in mind that it had no evidence before it that Miss Fay has taken any steps to strengthen her practice. It noted that it has no evidence of any training or learning since these incidents took place and it bore in mind that Miss Fay has stated in email correspondence to the NMC that she no longer wishes to work as a nurse.

However, the panel considered that there is a risk of repetition as Miss Fay has not demonstrated any insight or strengthened practice in respect of her misconduct. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 it therefore also finds Miss Fay's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Fay'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 9 months. The effect of this order is that Miss Fay'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

Ms Cockburn detailed the aggravating and mitigating features of the case. She went through the sanctions available to the panel and why each was or was not appropriate in the circumstances. Ms Cockburn submitted that the NMC seeks the imposition of a conditions of practice order for 12 months with a review as the panel has found Miss Fay's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Miss Fay'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:

- Miss Fay's failures to record medication administration on Lorenzo put patients at risk of harm
- Miss Fay's conduct demonstrated a pattern of similar incidents
- Miss Fay has not demonstrated insight
- Miss Fay has not taken any steps to strengthen her practice
- Miss Fay's limited engagement with the NMC

The panel also took into account the following mitigating features:

- [PRIVATE]

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 Miss Fay's practice would not be appropriate in the circumstances. The SG states that a caution order *'is only appropriate if the Fitness to Practice Committee has decided there's no risk to the public or to patients requiring the nurse, midwife or nursing associate practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practice Committee wants to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that there remained a risk to the public or to patients requiring Miss Fay's practice to be restricted, and that a caution order would therefore 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 Miss Fay'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 found that the following factors listed in the SG applied in this case:

- *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.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel had regard to the fact that these incidents happened in 2019 and the panel determined that it was in the public interest that, with appropriate safeguards, Miss Fay should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that 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 or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Miss Fay's case because the failings identified are remediable and the concerns identified can be addressed through the imposition of a conditions of practice order.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession,

and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

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 will send the NMC a report seven days in advance of the next NMC hearing or meeting from either:

- your line manager or
- your mentor or supervisor.

> 2. You must not administer medication unless supervised by another nurse until such time that you have been signed off as competent by your line manager, mentor or supervisor (who must be a registered nurse).
>
> 3. You will send your case officer 7 days before any review hearing evidence that you have successfully completed a medications administration course.
>
> 4. You must work with your line manager, mentor or supervisor to create a personal development plan (PDP). Your PDP must address the concerns about medication administration. You must:

- Send your case officer a copy of your PDP 7 days before any review hearing.

- Send your case officer a report from line manager, mentor or supervisor 7 days before any review hearing. This report must show your progress towards achieving the aims set out in your PDP.

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

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

7. 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.
   e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

8. 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.

9. 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 9 months. The panel determined that this was the minimum time necessary for Miss Fay to find a nursing job and demonstrate adherence to the conditions outlined above.

Before the order expires, a panel will hold a review hearing to see how well Miss Fay 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:

- Miss Fay's attendance at any future hearing.
- An indication of Miss Fay's future intentions in relation to her nursing career.
- A reflective statement which addresses the failings found proved in this hearing relating to medication administration.
- Evidence of any courses completed in relation to medication administration.

This will be confirmed to Miss Fay 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 is in Miss Fay'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 Cockburn. She submitted that the substantive order cannot take effect until the appeal period has lapsed. She invited the panel to impose an interim order to cover this period of appeal.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any potential period of appeal.

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

That concludes this determination.