Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 4 March 2024 – Friday, 8 March 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Virtual Hearing

Monday, 11 March 2024 – Tuesday, 12 March 2024

Name of Registrant:	Miriam Magdalene Charmaine Segarajasinghe
NMC PIN	09G1278E
Part(s) of the register:	RNMH: Registered Nurse Mental Health – Level 1 21 September 2009
Relevant Location:	Knowsley
Type of case:	Misconduct
Panel members:	Louise Fox (Chair, Lay member) Paul Hepworth (Lay member) Margaret Marshall (Registrant member)
Legal Assessor:	Attracta Wilson
Hearings Coordinator:	Max Buadi
Nursing and Midwifery Council:	Represented by Rebecca Patterson, Case Presenter
Ms Segarajasinghe:	Present and represented by Thomas Buxton, Counsel (instructed by the Royal College of Nursing)
Facts proved by admission:	Charges 1a(i), 1a(ii), 1b and 1c
Facts Proved:	None

Facts not proved:	Charges 1d
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (9 months with a review)
Interim order:	Interim conditions of practice order (18 months)

Panel consider whether it should recuse itself

The legal assessor had a matter to discuss with the panel. She said that there is information before the panel that both Ms Paterson, on behalf of the Nursing and Midwifery Council ("NMC") and Mr Buxton, on your behalf, both agree should not be before the panel. The legal assessor said that the information is contained within Witness 2's witness statement and also included in Witness 3's witness statement.

The legal assessor said that while Witness 3's witness statement is redacted, there is information pertaining to the outcome of an internal disciplinary proceeding. The legal assessor said that it was accepted by both Ms Paterson and Mr Buxton that this information was sent to the panel inadvertently and should not have been provided to the panel.

The legal assessor said that the panel must consider whether this is information that warrants a recusal as a panel or whether it is fair to proceed in these circumstances. The legal assessor advised the panel that, in deciding whether to recuse itself, it should apply the test for bias set out in *Porter v Magill* [2002] 2 AC. That is whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased.

The legal assessor said that the panel must be alert to conscious bias and unconscious bias. She reminded the panel that findings relating to a disciplinary matter are findings in relation to an investigation taken for a different purpose. She said the panel must consider whether it is likely that the panel could be biased by information that has been disclosed to it which should not have been. Further, it must consider whether, as an expert panel it is in a position to put the information it has read out if its mind both consciously and unconsciously and reach a decision that is fair to the NMC and to you.

Ms Patterson submitted that she had no comments to make on the legal advice.

Mr Buxton submitted that you are content to proceed and content with the legal advice that had been given. He submitted that any further delay would cause you inconvenience.

With regards to fairness, the panel took account of Mr Buxton's submissions and noted that you were content with proceeding with the hearing as any further disruption would cause you stress and inconvenience.

The panel concluded that it has enough experience to know that disciplinary procedures are different to NMC procedures and bore in mind that it will hear different evidence and take account of different circumstances. The panel considered that, as an experienced panel sitting in a judicial capacity, its focus would be on the evidence related to the incident on 12 July 2021 and would not be influenced in any way by any irrelevant information including the outcome of a disciplinary procedure.

The panel determined to proceed as it was of the view that it had enough experience to put the information it had read out of its mind.

Details of charge

That you, a registered nurse,

1) On 12 July 2021:

    a) Administered methadone to Patient A:

        i) By giving them a bottle containing 15mls to drink from when they were prescribed 5mls.

        ii) In the absence of a second checker.

b) Recorded in the controlled drug book that you had administered 5mg of methadone to Patient A when you did not know how much methadone Patient A had consumed.

c) Failed to record and/or report and/or escalate the medication error at charge 1a).

d) Your conduct at charge 1b) and/or 1c) was dishonest in that you intended to conceal your medication error.

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

After the charges were read, the panel heard from Mr Buxton, who informed the panel that you made full admissions to charges 1a(i), 1a(ii), 1b and 1c.

The panel therefore finds charges 1a(i), 1a(ii), 1b and 1c proved in their entirety, by way of your admissions.

Background

You commenced permanent employment at Victoria Garden Hospital (the Hospital) in October 2020. Prior to this you had worked as an agency nurse at the Hospital and other locations belonging to the overarching organisation Elysium Healthcare.

The Hospital is a mental health unit that provides care to patients with a range of mental health needs. It is split up into four wards.

Your usual place of work was on Roby Ward, a rehabilitation ward that cares for female patients. This ward had 12 beds.

On 12 July 2021, you worked your first shift on Bluebell Ward, an eight-bed secure ward caring for male patients. On this shift a number of allegations were raised in relation to

shortcomings in the administration of medication and recording in relation to Patient A and also your subsequent actions in relation to that error.

Amongst numerous other medications, Patient A was prescribed the controlled drug methadone and was prescribed a 15ml dose daily. This was to be divided into three 5ml doses administered over the course of the day.

You accepted that when you were administering Patient A's morning medications, rather than administering Patient A his 5ml dose, you instead handed him a bottle containing 15mls of methadone to drink from. You have also accepted that there was no second checker present for this administration which is required in accordance with the policy in place for the management and administration of controlled drugs.

There were concerns around the way you responded to this medication error. Despite not knowing how much methadone Patient A had consumed, you proceeded to record in the controlled drug book (the CDB) that 5 mgs (sic) of methadone had been administered to Patient A. Additionally, you did not record, report, or escalate the medication error you had made.

Witness 1, the charge nurse on shift, only became aware of the medication error when Patient A himself informed him later that morning at his multi-disciplinary team meeting (MDT).

It has been alleged that you dishonestly recorded the amount of methadone administered and the reason that you did not record/report or escalate the error was because you were intending to conceal the error that you had made.

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

Before Witness 3 was due to give evidence Ms Paterson informed the panel that parts of her application to postpone Witness 3's evidence should be heard in private as it relates to personal matters.

Mr Buxton did not oppose the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to Witness 3's personal circumstances, the panel determined to hold those parts of the application in private.

Decision and reasons on postponing Witness 3's evidence

Ms Patterson reminded the panel that Witness 3 was due to give evidence on day 3 of the hearing. [PRIVATE] Ms Patterson submitted that Witness 3 would prefer to give evidence on day 4 when he returns to work.

Mr Buxton did not oppose the application.

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

The panel determined to allow Witness 3, given the circumstances, to give evidence on day 4.

Decision and reasons on facts

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

The panel reminded itself 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: Charge nurse at the Hospital;
- Witness 2: Lead Nurse at the Hospital;
- Witness 3: Ward Manager at the Hospital.

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

The panel then considered the disputed charge and made the following finding.

Charge 1d

That you, a registered nurse,

1) On 12 July 2021:
   d) Your conduct at charge 1b) and/or 1c) was dishonest in that you intended to conceal your medication error.

This charge is found not proved.

In reaching its decision, the panel noted that the test for dishonesty is set out in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67.* The test is as follows.

When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The panel must determine whether your conduct was honest or dishonest by applying the (objective) standards of ordinary decent people. There is no requirement that a registrant must appreciate what they have done is, by those standards, dishonest.

In assessing your state of mind as to the relevant facts, the panel had regard to the contextual background and the particular circumstances in which you were working at the time of and leading up to the incident on 12 July 2021.

In your oral evidence [PRIVATE]. You took eight days leave at this time. On return from your leave Bluebell ward, on which you had been working, had been renamed to Roby ward and the number of patients on the ward had increased by five. The patients had complex needs and staffing levels had not been increased. During this period, the charge nurse transferred to another role and was not replaced and you effectively became the nurse in charge. You said you felt "out of your depth" because of your situation which was exacerbated by the covid-19 pandemic and its impact on staffing levels.

The panel also heard evidence from you and other witnesses regarding the impact of high levels of racial abuse from patients that you and other members of staff had suffered at the Hospital and how you felt this was not always dealt with in a timely and appropriate way.

The panel heard evidence from you, Witness 2 and Witness 3 about some concerns raised regarding your time management and productivity in 2021. Witness 2 said that you were spending too long on medication rounds and writing up notes. She said that your handovers were then delayed which meant staff had to stay beyond the end of their shift. Witness 2 said that she had been planning to discuss this with you more formally in supervision, but this had not happened by 12 July 2021. You told the panel that you were conscious that you needed to complete tasks in a timely way following these conversations.

You told the panel that you were due to be transferred to Sefton Ward on the 12 July 2021, which you were pleased about, and so were surprised and concerned when you learned on the morning of the 12 July 2021 that you were working on Bluebell Ward. Bluebell Ward was new to you and you were not familiar with the ward or the patients on the ward. These factors placed additional time pressures on you.

On 12 July 2021, you said that you were working with three other members of staff. One was an agency Health Care Assistant (HCA) who had not worked on the ward before, another HCA was carrying out one to one observations on Patient A and Witness 1 was the Charge Nurse leading the day shift. Witness 1 told the panel that they were also acting as site coordinator and conducting multi-disciplinary meetings off the ward on that day. You stated that you had difficult working relationship with Witness 1 as you did not always see eye to eye on how things should be done. You stated that there had previously been tensions between you, and on one occasion Witness1 had reprimanded you for allegedly going over his head. Witness 1, in his oral evidence, stated he had a good professional relationship with you but conceded there had been professional issues and agreed that there had been a conversation about going over his head regarding a dispute.

In your oral evidence and written reflections, you told the panel that with hindsight you can see that you were experiencing stress and burnout by 12 July 2021. You said that you accept you were not working at the standards required and all the factors above led to you not thinking straight and that this had an adverse effect on your performance at work.

You told the panel that you were assigned to complete the Medication round. Patient A was the only patient who was prescribed a Controlled Drug and two nurses were required to administer this drug. You gave evidence of that Witness 1 was present when you opened the Controlled Drugs Cupboard but then he left the clinic. You stated that you could not find him after this but you decided to administer the medication anyway. This included administering methadone without a second checker present which you knew to

be in breach of policy. You said that you were flustered, not thinking correctly and accepted that this was a big mistake.

You explained that you misread the amount of methadone prescribed and thought that Patient A was due 15 ml three times a day as opposed 5mls three times a day as prescribed. You explained that the medication was in a 30 ml brown bottle which held 15 ml methadone, and you judged the bottle as being half full. You therefore handed the patient the content of the bottle to drink. You said the patient took a sip of the bottle. He handed the bottle back to you and told you that he did not normally take this much. You realised that at this point you had made an error with the medication.

You said that you told the HCA who was undertaking one to one observations on Patient A to look out for any signs of a deterioration in his condition and if any was noticed to activate the alarm. You stated that you also asked the HCA to let Witness 1 know that you were looking for him should the HCA see Witness 1.

You told the panel you recorded 5mg in the book with a +/- sign by the running total to indicate this was approximate and it was your intention to find Witness 1, ask him to check the amount of methadone left in the bottle and in stock (recalibration) so you could work out how much Patient A had taken and correct the record in the CDB. The panel reviewed the CDB and noted that this method of recording the running total was not an unusual practice in the ward, to evidence liquid wastage. In your oral evidence you explained that you thought it was important to record straightaway that Patient A had received at least 5 ml of methadone. You said after this, you were unable to find Witness 1 and when you did speak to him about the medication error Patient A had already informed him of the error at the MDT. You said you discussed the need to recalibrate the methadone. It is your case that you asked Witness 1 to recalibrate at that time and he told you he would do the recalibration later.

You explained that after the error occurred, you continued the medication round as you felt under pressure to complete it. You said you knew your performance around time

management had been raised and there was only a two-hour window to ensure all the patients had received their medication. You accepted that you prioritised completing the medication round over ensuring that the medication error was escalated and you acknowledged that this was the wrong decision and that you were not thinking straight.

The NMC's case was that your medication error was concealed from senior members of staff for over two hours. Ms Paterson submitted that nobody looking at the CDB would know that there had been a medication error at 08:40 on 12 July 2021 because you had recorded "5 mgs given". Additionally, Witness 1 stated that you did not inform him of the medication error until you were confronted by him. Neither did you inform any other nurses or contact the patient's doctor.

Ms Paterson submitted that you knew you did not know how much methadone had been administered to Patient A and knew the amount you recorded, "5mgs" was not accurate but recorded it anyway. She submitted that this was evidence that your dishonesty.

The panel accepts your explanation for recording 5 mgs as the administered dose. It took into account the pressure you were working under at the time and that, on your own admission, you were not thinking straight. It concluded that in recording 5 mgs, you exercised very poor judgment but was not satisfied that you had dishonest intent to conceal the medication error or that your actions would be regarded as dishonest applying the standards of ordinary decent people.

The panel went on to consider the allegation of dishonesty in relation to 1c, failure to record and/or report and/or escalate the medication error. The panel noted that the NMC's case was that you concealed the medication error from senior members of staff for over two hours.

The panel accepted that on the balance of probabilities, you had looked for Witness 1 but had not found him. The panel took into account that Witness 1 was busy on that morning combining his duties as site coordinator with taking patients to their MDT meeting.

The panel noted that your account and Witness 1's account pertaining to when and how the error was reported are conflicting.

Witness 1 in his witness statement stated:

> *"I then went to the office on the Ward, where the Nurse was. I cannot recall what time this was exactly. I asked the Nurse if anything significant had happened on the drugs round. They did not tell me about the incident and so I asked them to join me in the clinic area. I asked the Nurse whether she had anything to report to me about Patient A's Methadone and they said that they had given the container to Patient A, and they had just taken a sip and given it back to them. I asked the Nurse why they had done this and why they had not measured the Methadone out using a syringe but the Nurse did not respond. I then advised the Nurse on the correct procedure for dispensing the medication. I cannot recall the exact time at which this was."*

You stated that Witness 1 spoke to you first in the clinic, not the office, and he asked you about the medication error immediately. You said, in response, you explained to him what had happened.

The panel noted that there was a dispute between you and Witness 1 as to whether you volunteered information to him regarding the medication error or that you disclosed it only when prompted by Witness 1. Both you and Witness 1 have been consistent in your accounts given contemporaneously and in your oral evidence. There is no corroborative evidence to support either version of events. The panel have therefore been unable to resolve this dispute on the balance of probabilities.

The panel considered all the circumstances surrounding the events on the 12 July 2021. It noted that the HCA was present in Patient A's room when the incorrect dose was administered and that Patient A was also aware of the error as he told you that he was not usually administered that amount of methadone. The panel accepted that anyone viewing

the CDB would see that there was no second checker recorded for the morning dose which was contrary to policy and was likely to initiate an investigation. The panel also noted that if not at the second dose, then certainly by the third dose of the day, it would be apparent that the stock balance was wrong. The panel accepted your evidence that you knew that some people knew of the error immediately and others would be aware of it very soon.

Additionally, in considering motivation and intent, the panel considered your oral evidence as to the expected consequences for a nurse following a first medication error. It was your belief that in such circumstances, the Hospital's response would be supportive and would make sure that the member of staff would get appropriate supervision and retraining. Therefore, in the panel's view that there would be no motivation for concealment.

The panel also bore in mind that it heard evidence that you are a nurse of good character. It took account of the testimonials provided which attest to your honesty and integrity and speak highly of your abilities as a nurse.

You have been consistent with accepting what you had done was wrong at all times and throughout your evidence. However, you deny that your actions in either recording or escalating the medication error were dishonest.

The panel also bore in mind that Witness 3 at the conclusion of his evidence, spontaneously, could not be more complimentary about your nursing skills, wished you well and said he was sorry to see you in these circumstances.

Based on the evidence in the round, the panel accept that your actions described in the charges appear to be out of character for you. However, compounded by the high level of racism, the challenging work environment for the previous months and on that day, your personal circumstances, your relationship with Witness 1 and your unexpected allocation to Bluebell ward which was unfamiliar to you, the panel is satisfied on the balance of

probabilities that these factors had an impact on your state of mind and your practice on that day.

In the light of all of these circumstances, the panel determined that, on the balance of probabilities, you were not seeking to conceal the medication error.

The panel determined that on the balance of probabilities, your actions as charged in 1d were not dishonest. The panel carefully considered the subjective and objective limbs of the *Ivey* test. It directed itself to your state of mind to the relevant facts at the time of and immediately following the medication administration error. It noted the context in which you were working, the pressures you were working under and took into account your evidence that you were focused on completing the medication round against the background of previous concerns in relation to your time management and productivity.

The panel, having considered the evidence in the round and applied the Ivey test, are not satisfied on the balance of probabilities that on 12 July 2021, your conduct at charge 1b and 1c was dishonest.

Therefore the panel found charge 1d not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the charges you have admitted amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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.

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.'*

NMC Submissions on misconduct

Ms Paterson invited the panel to take the view that the facts found proved amount to misconduct. She directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, your actions amounted to misconduct.

Ms Paterson submitted that the panel should not have much difficulty in finding that your conduct was serious in this case because it relates directly to patient care.

Ms Paterson submitted that insufficient action was taken to mitigate the risk to Patient A after becoming aware of it. She submitted that each of the charges admitted are sufficiently serious so as to amount to misconduct.

NMC Submissions on impairment

Ms Paterson 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 Paterson reminded the panel of the Dame Janet Smith test from the Fifth Shipman report and submitted that the first three limbs are engaged.

Ms Paterson submitted that Patient A was placed at an unwarranted risk of harm. She submitted that the overdose of methadone was avoidable had there been a second checker. She further submitted that the risk to Patient A after it had been administered was higher than it should have been because the incident was not immediately reported or escalated in line with the Hospital's policies and procedures.

Ms Paterson submitted that the inaccuracy in the CDB put Patient A at an unwarranted risk of harm because the inaccuracy does not ensure that all future medical interventions are fully and accurately informed.

Ms Paterson submitted that members of the public would be extremely concerned that a nurse had administered controlled drugs without a second checker present and that they had handed a bottle of methadone to a patient without measuring its contents first. She further submitted that the public would also be concerned that immediate action was not taken to mitigate any risks of overdose. She submitted that such conduct brings the profession into disrepute and the fundamental tenets of the profession have been breached.

Regarding current impairment, Ms Patterson submitted that you have acknowledged the seriousness of the misconduct in charges 1a to 1c and recognises the impact that it has on public confidence in the profession and that it undermines professional standards.

Ms Paterson submitted that the issue appears to be around feeling under pressure and experiencing burnout. She submitted that you are in receipt of therapy to better recognize the signs and symptoms. She submitted that the panel will have to ask itself whether it considers the root cause has been sufficiently addressed to prevent repetition. Ms Paterson submitted that if the panel found there remained a risk to the public, a finding of impairment on public interest grounds would also be required.

Mr Buxton submissions on misconduct

Mr Buxton reminded the panel that in your reflections you acknowledged that the standard of performance fell seriously short of what would reasonably be expected in the circumstances.

Mr Buxton submissions on impairment

Mr Buxton submitted that he accepted that in the past and on this single instance the first three limbs of the Dame Janet Smith test from the Fifth Shipman report are engaged.

Regarding Patient A being placed at an unwarranted risk of harm, Mr Buxton submitted that efforts were made to locate Witness 1 and once the error was discussed, steps were taken outside of your control to put things right. He submitted that it is not right that nothing was done for two hours. Further, the HCA was notified and told to take appropriate action as advised.

Regarding current impairment, Mr Buxton referred the panel to your reflections and submitted that you have reflected long, hard and fully on the causes and the reasons you

took these unwise steps. He submitted that, from your reflections, you recognise the need to be aware of your performance levels and will look to this in the future.

Mr Buxton submitted that the breaches of protocol and procedure were effectively what led to the mistake. He submitted that your thought processes, decision making and performance were severely impaired as a result at the time and you acknowledged this. He submitted that your insight is fully developed.

Mr Buxton submitted that the panel may think that you have made a positive start in addressing the root cause by taking responsibility for what happened and benefitting from professional help in this regard. He submitted that this would be demonstrated in due course when you return to work. He submitted that the root cause has been addressed sufficiently.

Mr Buxton accepted that you have not been able to put into practice the insight and learning that you have undertaken. Mr Buxton submitted that having regard to your past record, your reflection indicates that you are capable and would be capable upon return to practice of kind, safe and professional practice.

Mr Buxton submitted that a fully informed bystander would not come to the conclusion that a finding of impairment was required.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

8 Work co-operatively

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

10.3 complete records accurately…

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

To achieve this, you must:

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

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

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

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

To achieve this, you must:

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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 the misconduct in charges 1a to 1c was serious. You gave Patient A an overdose of a controlled drug. While Patient A was not harmed by your medication error, Patient A was placed at a significant risk of harm.

In the panel's view, the risk of significant harm your conduct placed Patient A in was compounded by the fact that you continued to demonstrate poor practice by not recording accurately or reporting or escalating the medication error. This is despite the fact that you were an experienced nurse who was aware of how to deal with controlled drugs and the

fact that you accepted that you were aware of the Hospital's policies and procedures in place pertaining to the recording, reporting and escalation of medication errors.

The panel also noted that your recording in the CDB, whilst not dishonest, potentially delayed appropriate action being taken to mitigate the risk. It was of the view that not using a second checker removed the safeguard put in place to avoid mistakes when administering controlled drugs.

The panel was of the view that your actions did fall short of the conduct and standards expected of a nurse and were serious departures from the standards and would be considered deplorable by fellow practitioners.

In light of the above the panel determined that the charges 1a to 1c, individually and collectively, amounted to a serious departure from appropriate standards expected and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only*

whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel determined that limbs a, b and c were engaged by your misconduct.

The panel was of the view that your conduct placed Patient A at risk of unwarranted harm by not measuring out correct dose of methadone and not recording, reporting or escalating the error.

The panel determined that your misconduct had breached fundamental tenets of the nursing profession by not delivering fundamentals of care effectively, not raising or escalating any concerns about patient safety and therefore brought its reputation into disrepute.

The panel recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether you would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you have provided evidence of insight and remorse.

Regarding insight, the panel took account of your oral evidence and your reflective pieces which addressed the incident on 12 July 2021.

The panel noted that in your reflective statements you stated:

> *"There were a lot of proceeding events that led to me being significantly below my normal performance level on the day. My stress level was adversely affecting my performance in work to a point that I was probably not capable of fulfilling my duties safely. I, at the time of the incident did not realise this. I will not allow myself to get to this point again.*

In future, if the environment is too difficult and my performance is under par and I feel that I am not getting the appropriate support I need, I will be proactive in resolving the issues and getting support rather than carrying on….

In the worst case scenario, as with this incident, I will seek help, report myself as unfit [PRIVATE] or resign if necessary."

The panel was of the view that you have demonstrated good insight and were able to recognise the impact of what happened, what went wrong and recognised the impact your misconduct had on patients, colleagues and the nursing profession. The panel noted that throughout your evidence you acknowledged what you should have done and what how you would act differently in the future. The panel also noted that you were very remorseful in your oral evidence.

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 you have taken steps to strengthen your practice.

The panel noted that you have not practiced as a registered nurse since the incident and therefore have not been able to provide evidence of ongoing safe practice in a practice environment. It also noted that it has no evidence before it of training courses undertaken since 20 September 2022. It noted that you have undertaken online reading and studying on some related topics.

The panel are encouraged that you have recognised the impact that multiple stressors impacted your practice as a nurse. It is also encouraged that you are currently seeking therapy to address this.

However, the panel bore in mind that you said that at the time you did not recognise the signs of this level of stress and did not take advice from others who raised it with you. You

have not stated how you would recognise the triggers in future so you could take preventative steps to be able to continue practicing safely.

The panel is of the view that while the risk of repeating the same error may be low, it was of the view that a risk of repetition, albeit a low one, remains. It considered that if you found yourself in similar circumstances, under significant personal and professional stressors again, you may not recognise the triggers and this may impact on your decision-making and clarity of thought and subsequent ability to keep patients safe.

The panel therefore decided that a risk of repetition remains and 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 was satisfied that, having regard to the nature of the misconduct in this case, “the need to uphold proper professional standards and public confidence in the profession would be undermined” if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if your fitness to practise were not found to be impaired.

For all the above reasons the panel determined that a finding of impairment on public interest grounds is required.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 9 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Ms Paterson submitted that the appropriate sanction would be a conditions of practice order with a review. She took the panel through the aggravating and mitigating factors she considered to be engaged in this case.

Ms Patterson submitted that because there remains a risk to patient safety, albeit a low one as identified by the panel, taking no further action nor imposing a caution order would sufficiently protect the public. She submitted that these sanctions are not restrictive and therefore there would be no safeguards in place to protect the public.

Ms Patterson referred the panel to the NMC Guidance and invited the panel to impose a conditions of practice order and put forwards a list of recommended conditions. Ms Patterson submitted that the length of the order should be no less than six months as this would be too short in the circumstances to allow you to develop, practice and provide evidence to a reviewing panel.

Mr Buxton submitted that he agreed with the submissions of Ms Paterson and invited the panel to impose a conditions of practice order. He also submitted that six months would be

the minimum length of time for a conditions of practice order. Mr Buxton also agreed with conditions proposed by Ms Paterson.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, it may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your conduct placed Patient A at a direct risk of significant harm.

The panel also took into account the following mitigating features:

- Good evidence of insight;
- This was an isolated incident in the context of a long and otherwise unblemished career;
- Early and consistent admissions at local level and throughout the NMC proceedings;
- Challenging personal circumstances;
- General challenging working environment during Covid 19;

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG and considered the following factors were relevant in your 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;*
- *Potential and willingness to respond positively to retraining;*
- *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 a conditions of practice would be the least restrictive sanction that it could impose that would protect the public and return you safely to unrestricted practice.

The panel was satisfied that there is an area of your practice, pertaining to patient protection that needs to be addressed. It determined that it would be possible to formulate

appropriate and practical conditions which would address the failings highlighted in this case. The panel bore in mind that throughout these proceedings you have demonstrated a willingness to strengthen your practice and accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that this was an isolated incident in an otherwise long career as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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 wholly disproportionate and would not be a reasonable response in the circumstances of your case. In addition the panel considered this was a single, albeit serious incident, the failings identified could be remediated and removal from the NMC register would not be in the public interest.

Having regard to the matters it had 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 must limit your practice to one substantive employer which may be an agency. If working via an agency or as bank staff, you must limit your nursing practice to contracts of a minimum of 3 months working in the same unit or on the same ward.

2. When administering or managing controlled drugs, you must ensure that you are under the direct supervision of a registered nurse.

3. You must send your case officer evidence that you have successfully completed training in the management and administration of controlled drugs, at least 7 days before the review hearing or meeting.

4. You must meet with your line manager, mentor or supervisor on a monthly basis to ensure you are making progress towards meeting these conditions.

5. You must keep monthly reflections. The reflections will:

    - Reflect on your progress in safe administration of controlled drugs
    - Reflect on your progress in recognising and managing stressors that have the potential to impact on your practice.

6. You must share your monthly reflections with your supervisor, line manager or mentor at your monthly meetings for discussion.

7. You must send copies of your monthly reflections to your case officer within 7 days of the next review hearing or meeting.

8. You must provide a report from your line manager, mentor or supervisor at least 7 days before the next review hearing or meeting regarding:

    - your ability to manage and administer controlled drugs safely;
    - your ability to manage stressors that may have the potential to impact on your ability to practice safely.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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 considered that this will be sufficient time for you to obtain employment, complete relevant training and provide evidence of kind, professional and safe practice.

Before the order expires, a panel will hold a review hearing. 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.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Paterson. She submitted that given the panel's findings in relation to sanction an interim conditions of practice order for a period of 18 months will be appropriate. She also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

Mr Buxton made no representations regarding the interim 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.

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

That concludes this determination.