Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 10 November 2025 – Tuesday, 11 November 2025

Virtual Meeting

Name of Registrant:	Paul Anthony Cowan
NMC PIN:	88H0261S
Part(s) of the register:	Registered Nurse, Sub Part 1 Mental Health Nurse, Level 1 (5 December 1991)
Relevant Location:	Scotland
Type of case:	Misconduct
Panel members:	James Carr (Chair, Lay member) Diane Gow (Registrant member) Robert Marshall (Lay member)
Legal Assessor:	Sharmistha Michaels
Hearings Coordinator:	Zahra Khan
Facts proved:	Charges 1, 2c, 3a, and 3c
Facts not proved:	Charges 2a, 2b, 2d, 2e, and 3b
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months) with a review**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mr Cowan's registered email address by secure email on 29 September 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, that the meeting will take place on or after 4 November 2025, and the fact that this meeting will be heard virtually.

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

Details of charge

That you, a registered nurse:

1) On 10 June 2021 you failed to administer medication to one or more patients in Schedule 1.

2) You failed to ensure the safety of one or more patients set out in Schedule 1 when you were told by staff that you had not administered the evening medication round on 10 June 2021 in that you:

a) Failed to seek clinical advice regarding the patients who were not administered their blood sugar and blood thinning medication.

b) Failed to notify the Care Inspector through the e-form system.

c) Failed to make an entry in the quality assurance system named RADAR.

d) Failed to contact the out of hours Social Work Department who would decide whether an AP1 referral (Adult Support & Protection Form) was needed.

e) Failed to contact the family members or next of kin of the affected patients.

3) Breached your professional duty of candour in that you:

a) Failed to raise concerns with management about not administering the evening medication round on 10 June 2021.

b) Failed to inform the patient's families of the errors.

c) Failed to report the errors on the quality assurance system (RADAR).

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

Schedule 1

Patient A
Patient B
Patient C
Patient D
Patient E
Patient F
Patient G

Background

On 27 October 2021, Mr Cowan was referred to the NMC by Thistle Healthcare, his former employer.

The regulatory concerns relate to incidents that took place whilst Mr Cowan was working as Deputy Care Home Manager at Millbrae Care Home ('the Home') on 10 June 2021.

The referral outlined that, while Mr Cowan was on shift on the Wallace Unit at the Home on 10 June 2021, he failed to administer prescribed medication to five patients.

The night shift staff (a health care assistant and the nurse in charge) commenced their night shift on Wallace Unit and noticed that the teatime medication was not given. They called Mr Cowan to confirm whether the medication was not given or not signed for. During the telephone conversation, Mr Cowan stated he would sort the matter with the Home's manager the following day.

On 14 June 2021, the Home's manager was informed of the errors by a member of staff who was conducting a MAR charts audit, that medication had not been signed for on 10 June 2021.

Mr Cowan admitted to failing to administer the medication within a statement dated 16 June 2021.

The investigation found that Mr Cowan did not follow protocol to address the medication errors and safeguard the residents involved. He was subsequently summarily dismissed for gross misconduct on 5 July 2021.

This referral resulted in an investigation by the NMC, which identified the following regulatory concerns:

1. Poor medications practice – in that Mr Cowan failed to administer the evening medication round on 10 June 2021.

2. Failure to safeguard – in that Mr Cowan failed to ensure action was taken to protect patients when he was told by staff that he had not administered the evening medication round on 10 June 2021.

3. A failure to comply with the duty of candour – in that Mr Cowan:

    a. Failed to raise concerns with management about not administering the evening medication round on 10 June 2021.

b. Failed to inform the resident's families of the errors.

c. Failed to report the errors on the quality assurance system (RADAR).

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and the internal investigation statement from Mr Cowan.

The panel was aware that the burden of proof rests with 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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Registered nurse employed by Greencross Care Home as a Care Home Manager at the time of the incidents.

- Witness 2: Registered nurse employed by Millbrae Care Home as a Care Home Manager at the time of the incidents.

The panel also had regard to Mr Cowan's statement titled 'Statement regarding failure to administer medications' dated 16 June 2021.

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

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

Charge 1

"That you, a registered nurse:

1) On 10 June 2021 you failed to administer medication to one or more patients in Schedule 1"

This charge is found proved.

In reaching its decision, the panel took into account Mr Cowan's statement at the local investigation (titled 'Statement regarding failure to administer medications') dated 16 June 2021; an email from Mr Cowan to Witness 2 dated 15 June 2021; Witness 1's witness statement dated 22 March 2024; and Witness 2's witness statement dated 25 April 2025. The panel also looked at each individual patient's Medication Administration Record Sheet ('MAR chart').

The panel noted that in his statement dated 16 June 2021, Mr Cowan stated:

'On the evening of Thursday 10th June 2021; I was the nurse on duty… As the nurse on duty [and having no Senior Care in attendance]; it was my duty to administer these medications… I had every intention of doing so… forgetting that I had not administered any of the teatime medications… This was my responsibility alone, and I accept the consequences of my failure to discharge my duties on this occasion… On reflection; my error was caused by not prioritising my tasks… In all my career; I have never before neglected to administer a medication round…'.

In an email dated 15 June 2021, Mr Cowan told Witness 2:

'Did I not discuss this with you on Friday? I meant to. Sorry if I didn't.

I don't know what to say. I got caught up with […] in room 1, then was doing dressings; and I completely lost track of the medications.

In all my years in nursing; that has never happened. I'm really sorry…'.

The panel also had regard to Witness 1's witness statement dated 22 March 2024, in which she wrote:

> *'On 10 June 2021, Paul was on shift at Millbrae Care Home when he made a medication error by not administering medication to 7 residents at teatime (roughly 5pm). It was discovered that Paul failed to administer medication when the Senior Carer, [Mr 1], started the nighttime round of medication at roughly 9pm and found that there were missing signatures next each resident's name. [Mr 1] informed the Nurse in Charge, [Ms 1], of his discovery. Both [Mr 1] and [Ms 1] conducted a count of the medication and found that the same number of medications that were to be administered remained in the cupboards which confirmed that a medication error had occurred…'.*

Further, Witness 2's witness statement dated 25 April 2025 stated:

> *'… . I remember trying to call Mr. Cowan on 14 June. However I was unable to contact him. I sent him an email asking for an update regarding the missed medications round on 10 June. He replied stating that "[he doesn't] know what to say" and that he "lost track of the medications". He also apologised for the events… I spoke to Mr. Cowan later on 16 or 17 June 2021. I do not remember the specific date. I asked him about the missed medication round. Although he was defensive about it, he admitted to missing the medication round on 10 June 2021. I asked him why this had happened, and he stated that he had a very busy shift and had forgotten to do it. As I mentioned, I was present on then day shift of 2021, and I did not recall it being particularly busy. I did recall, however, that the next day shift had been particularly busy. I asked him if he was referring to the following day shift. He replied that he did not know why he missed the medication round, but that it was the first time this ever happened. He did not provide any further explanations or mention anything regarding…'.*

The panel reviewed the MAR charts for Patients A to G. While the MAR charts confirmed that each patient had prescribed medication due at teatime, the panel found the charts to be poor quality copies and therefore difficult to interpret and of limited evidential assistance, as they merely recorded what was prescribed.

The panel placed greater weight on Mr Cowan's own admissions in his statement and his email to Witness 2. He accepted that he had failed to administer the scheduled mediations. The panel also accepted the corroborating evidence from Witnesses 1 and 2 that prescribed medications were due but had not been administered.

In these circumstances, the panel was satisfied, on the balance of probabilities, that Mr Cowan failed to administer medication to one or more patients in Schedule 1 on 10 June 2021.

Charge 1 is therefore found proved.

The panel sought further evidence from the NMC

At the outset of its deliberations on charge 2, the panel sought further evidence from the NMC, specifically the witness statements from other nurses that appeared to be listed as supporting documents in Witness 1's investigation on 21 June 2021.

However, the NMC responded to the panel's query by email dated 10 November 2025 stating:

> *'… In terms of the documents requested we do not have these contained in the CE masters or CPP masters. These documents were not requested from the Referrer…'.*

Charge 2a

> *"*You failed to ensure the safety of one or more patients set out in Schedule 1 when you were told by staff that you had not administered the evening medication round on 10 June 2021 in that you:
>
> a) Failed to seek clinical advice regarding the patients who were not administered their blood sugar and blood thinning medication".

This charge is found NOT proved.

In reaching its decision, the panel took into account Witness 1's witness statement dated 22 March 2024; the Investigation Report carried out by Witness 1 on 21 June 2021; and the Home's Medication Errors and Near Misses Policy and Procedure. The panel noted, however, that the evidence available to support this particular charge was limited.

Accordingly, the panel approached the charge with caution, assessing the reliability and relevance of the hearsay evidence and having regard to the principles concerning 'sole and decisive' evidence as set out in *Thorneycroft v NMC* [2014] EWHC 1565.

The panel noted that in her witness statement dated 22 March 2024, Witness 1 stated:

> *'… None of the expected steps following a medication error was adhered to by Paul…'*

The panel also considered the Investigation Report dated 21 June 2021, which stated:

> *'… Deputy Manager PC deputy did not administer 6pm medications on 10/06/2021 to residents in Wallace Unit.*
>
> *When called at home on 10/06/2021 by night staff who had noticed the medication Deputy Manager PC did not advise night staff during telephone call best practice to follow.*
>
> *Deputy Manager PC did not follow due process for reporting and recording medication errors. Deputy Manager PC gave evidence that he is fully aware of these processes…'.*

The panel then considered paragraph 5.5 the Medication Errors and Near Misses Policy and Procedure, which states:

> *'**5.5 Action After the Incident Has Occurred – Staff***

After a medication error or near miss has occurred and all necessary immediate actions have been taken, it is important that there must be an opportunity for the staff to discuss the incident with their manager…'.

The panel accepted that the policy created an expectation that Mr Cowan should have sought appropriate clinical advice following the incident. However, the panel had before it very limited evidence demonstrating that he failed to do so. At the time the error was brought to his attention, Mr Cowan was at home. The panel considered that at that time of the evening responsibility for seeking clinical advice may have rested with the staff on duty who discovered the error. The absence of the additional supporting witness statements, which the panel had sought but which were not available, further limited the evidential basis upon which it could rely.

The panel therefore concluded that the NMC had not provided sufficient evidence to establish charge 2a on the balance of probabilities.

Charge 2a is therefore found not proved.

Charge 2b

"You failed to ensure the safety of one or more patients set out in Schedule 1 when you were told by staff that you had not administered the evening medication round on 10 June 2021 in that you:

b) Failed to notify the Care Inspector through the e-form system".

This charge is found NOT proved.

In reaching its decision, the panel took into account Witness 1's witness statement dated 22 March 2024; Witness 2's witness statement dated 25 April 2025; the Investigation Report carried out by Witness 1 on 21 June 2021; the Home's Medication Errors and Near Misses Policy and Procedure and Adult Support and Protection Policy. The panel noted that the evidence available to support this specific charge was limited.

The panel noted that Witness 1's statement dated 22 March 2024 focused primarily on the potential risk of harm arising from the missed medication rounds but did not identify that any actual harm occurred.

Further, the panel noted Witness 2's statement dated 25 April 2025, in which she stated:

> *'… It is relevant to state, however, that no actual harm came from the missed medication round. If I remember correctly, most of the medication missed was not time sensitive or involved any high risk of harm to the patients if missed…'.*

However, the panel noted that two of the medication omissions related to anticoagulant therapy and diabetes management which the panel concluded did carry some risk.

The panel then had regard to paragraph 5.4 of the Medication Errors and Near Misses Policy, which states:

> *'**5.4 Action to Be Taken by The Nurse in Charge/Senior Manager***
>
> *… Once the Service User is stable, the Nurse in Charge/ Senior Manager/ Registered Manager must:*
>
> - *Ensure that a Care Inspectorate notification is made, if there was harm to the Service User…'.*

Based on the evidence before it, the panel was satisfied that no actual harm resulted from the missed medication rounds. As the policy requires notification only where harm has occurred and does not extend this requirement to situations involving potential harm, the panel could not be satisfied that Mr Cowan had a duty to notify the Care Inspector in these circumstances.

The panel also noted that although the Investigation Report suggested that Mr Cowan 'knew' he should have notified the Care Inspector, no supporting evidence was provided to confirm this, nor was there evidence before the panel establishing Mr Cowan's familiarity with the e-form notification process.

In these circumstances, the panel concluded that the NMC had not provided sufficient evidence to establish that Mr Cowan failed in a duty that, according to the relevant policy, did not arise.

Charge 2b is therefore found not proved.

Charge 2c

> *"*You failed to ensure the safety of one or more patients set out in Schedule 1 when you were told by staff that you had not administered the evening medication round on 10 June 2021 in that you:
>
> c) Failed to make an entry in the quality assurance system named RADAR".

This charge is found proved.

In reaching its decision, the panel took into account Witness 1's witness statement dated 22 March 2024, and the Home's Medication Errors and Near Misses Policy.

The panel noted that in her witness statement dated 22 March 2024, Witness 1 stated:

> *'… None of the expected steps following a medication error was adhered to by Paul. Senior management, above care home level, found no RADAR reports regarding the medication errors of 10 June 2021…'.*

The panel then had regard to paragraph 5.4 of the Medication Errors and Near Misses Policy, which states:

> *'**5.4 Action to Be Taken by The Nurse in Charge/Senior Manager***
>
> ***…***
>
> - *Ensure the incident is recorded on the Service User's notes and an incident log made'.*

Although the policy does not specifically reference the RADAR system by name, the panel considered it reasonable to infer that RADAR constitutes the 'incident log' referred to in the policy. The absence of any RADAR entry, as confirmed by Witness 1, therefore indicates that this procedural requirement was not followed.

The panel had evidence that Mr Cowen was a Band 6 nurse and Deputy Manager of the Home who had previously managed medication errors within the work setting. The panel concluded that as such he had a greater knowledge of the policy rules and guidance associated with medicine errors and what was expected in those circumstances.

In these circumstances, the panel determined that, on the balance of probabilities, Mr Cowan failed to make an entry in the quality assurance system named RADAR.

Charge 2c is therefore found proved.

Charge 2d

> "You failed to ensure the safety of one or more patients set out in Schedule 1 when you were told by staff that you had not administered the evening medication round on 10 June 2021 in that you:
>
> > d) Failed to contact the out of hours Social Work Department who would decide whether an AP1 referral (Adult Support & Protection Form) was needed".

This charge is found NOT proved.

In reaching its decision, the panel took into account Witness 1's witness statement dated 22 March 2024. However, the panel noted that the evidence before it in support of this charge was limited.

In her witness statement dated 22 March 2024, Witness 1 stated:

> *'… When Paul was informed of the error, he should have done the following:*

…

- Contact the out of hours Social Work Department who would decide whether an AP1 referral (Adult Support & Protection Form) was needed…'.

The panel accepted that Witness 1 described an expectation that the out of hours Social Work Department should have been contacted. However, the panel did not have sufficient evidence to demonstrate that this expectation amounted to a clear duty on Mr Cowan's part. The panel also noted that no policy or procedural document was provided to confirm that such a referral was required in these circumstances.

Further, the panel had no evidence before it establishing that Mr Cowan did not contact the out of hours Social Work Department. The panel also recognised that at the relevant time (approximately 22:30) Mr Cowan was at home, and there is evidence suggesting he intended to address the issue the following morning.

Given the limited evidence supplied by the NMC, and in the absence of material demonstrating both a duty to contact the department and a failure to do so, the panel was not satisfied on the balance of probabilities that Mr Cowan failed to make the required contact.

Charge 2d is therefore found not proved.

Charge 2e

"You failed to ensure the safety of one or more patients set out in Schedule 1 when you were told by staff that you had not administered the evening medication round on 10 June 2021 in that you:

e) Failed to contact the family members or next of kin of the affected patients".

This charge is found NOT proved.

In reaching its decision, the panel took into account Witness 2's witness statement dated 25 April 2025, and the telephone call log between the NMC case officer and Witness 2 on 5 March 2024. However, the panel noted that the evidence available to support this charge was limited.

The panel noted that Witness 2, in her witness statement dated 25 April 2025, stated:

> *'… None of the expected steps following a medication error was adhered to by Paul… Although there is no evidence to support this, it is believed that Paul did not contact the family members of the residents because the family members had no prior knowledge of the errors when [Witness 2] notified them...'.*

However, the panel also had regard to the telephone call log between the NMC and Witness 2 dated 5 March 2024. When Witness 2 was asked how it was established that Mr Cowan did not contact family members, she:

> '*explained that once she reported the matter to the seniors within Thistle healthcare, she had no involvement with investigation and so is unsure how that conclusion was drawn'*.

Further, when asked whether she herself contacted called the families of the patients, the note states that Witness 2:

> *'does not recall but believes she did not'*.

The panel found inconsistencies between Witness 2's formal statement and her earlier account. Given these contradictions, and in the absence of any other reliable evidence demonstrating that Mr Cowan failed to contact family members or next of kin, the panel could not be satisfied that this had been proved.

Charge 2e is therefore found not proved.

Outset of charge 3

At the outset of its deliberations on charges 3a, 3b, and 3c, the panel had regard to the NMC guidance titled 'Making decisions on dishonesty charges and the professional duty of candour' (Reference: DMA-8, last updated on 6 May 2025).

Charge 3a

> **"**Breached your professional duty of candour in that you:
>
> a) Failed to raise concerns with management about not administering the evening medication round on 10 June 2021".

This charge is found proved.

In reaching its decision, the panel took into account the NMC's guidance; Mr Cowan's statement at the local investigation (titled 'Statement regarding failure to administer medications') dated 16 June 2021; an email from Mr Cowan to Witness 2 dated 15 June 2021; Witness 1's witness statement dated 22 March 2024; Witness 2's witness statement dated 25 April 2025; the Investigation Report carried out by Witness 1 on 21 June 2021; and the Home's Medication Errors and Near Misses Policy.

The panel had evidence that Mr Cowen was a Band 6 nurse and Deputy Manager of the Home who had previously managed medication errors within the work setting. The panel concluded that as such he had a greater knowledge of the policy rules and guidance associated with medicine errors and what was expected in those circumstances.

The panel noted that Witness 2 was unequivocal in stating that she had been on shift on 10 and 11 June 2021. In her witness statement dated 25 April 2025, she stated:

> *'… I recall speaking to other members of staff. I do not remember who these were, but I recall being told that Mr. Cowan had been telling the staff that I had already been made aware of the missed medication round. It is important to point out that I had been on shift both on 10 and 11 June 2021, and I was not made aware of the missed medication round by anyone on either day…'.*

The panel also noted hearsay evidence from Witnesses 1 and 2 suggesting that Mr Cowan had stated he would discuss the error with Witness 2 on the morning of 11 June 2021. However, there is no acknowledgement or corroboration of this in Mr Cowan's own statement dated 16 June 2021.

The panel also noted the email dated 15 June 2021 from Mr Cowen to Witness 2, in which he stated:

> *'Did I not discuss this with you on Friday? I meant to. Sorry if I didn't.*
>
> *I don't know what to say. I got caught up with […] in room 1, then was doing dressings; and I completely lost track of the medications.*
>
> *In all my years in nursing; that has never happened. I'm really sorry'.*

Having considered the evidence, the panel was satisfied that Mr Cowan failed to escalate the missed medication rounds to management in line with his professional duty of candour. This failure to raise concerns constituted a breach of the requirement to be open and transparent when something has gone wrong.

In these circumstances, the panel determined that it was more likely than not that Mr Cowan breached his professional duty of candour in that he failed to raise concerns with management about not administering the evening medication round on 10 June 2021.

Charge 3a is therefore found proved.

Charge 3b

> **"**Breached your professional duty of candour in that you:
>
> b) Failed to inform the patient's families of the errors".

This charge is found NOT proved.

In light of its findings in charge 2e, where the panel concluded that there was insufficient and inconsistent evidence to establish that Mr Cowan failed to contact the family members or next of kin of the affected patients, the panel was unable to determine that a breach of the professional duty of candour occurred in this respect.

Accordingly, and for the same reasons, the panel did not find charge 3b proved.

Charge 3c

"Breached your professional duty of candour in that you:

c) Failed to report the errors on the quality assurance system (RADAR)".

This charge is found proved.

In reaching its decision, the panel took into account the NMC's guidance; Mr Cowan's statement at the local investigation (titled 'Statement regarding failure to administer medications') dated 16 June 2021; an email from Mr Cowan to Witness 2 dated 15 June 2021; Witness 1's witness statement dated 22 March 2024; Witness 2's witness statement dated 25 April 2025; the Investigation Report carried out by Witness 1 on 21 June 2021; and the Home's Medication Errors and Near Misses Policy.

The panel noted Witness 1 stated, in her witness statement dated 22 March 2024, that:

'… When Paul was informed of the error, he should have done the following:

…

- Make an entry in the quality assurance system named RADAR…'.

The panel was satisfied that the Home's policies required medication errors to be recorded through its quality assurance mechanisms, and that RADAR was the system through which such reporting was expected to occur. The panel considered that, if Mr Cowan had taken

steps to fulfil this duty, he would have raised or documented the error within the RADAR system. However, no such entry was made.

In the absence of any evidence from Mr Cowan indicating that he reported the errors or attempted to do so, the panel concluded that he failed to make the required RADAR entry. The panel was therefore satisfied that this omission represented a failure to act in an open and transparent manner as required under the professional duty of candour.

Accordingly, the panel determined that it was more likely than not that Mr Cowan breached his professional duty of candour by failing to report the errors on RADAR.

Charge 3c is therefore found 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 Mr Cowan's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, 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 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, Mr Cowan's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The NMC referred to paragraphs 1, 1.2, 1.4, 8, 8.1, 8.5, 8.6, 14, 14.1, 14.2, 14.3, 19, 19.1, 20, and 20.1 of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ('the Code').

The NMC's written submissions in relation to misconduct states:

> *'**Misconduct***
>
> *9. The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:*
>
> > *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.*
>
> *10. As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively*
>
> > *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.*
> >
> > *And*
> >
> > *'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.*
>
> *11. Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct.*

12. We consider the following provision(s) of the Code have been breached in this case….

13. The areas of concern identified relate to basic nursing skills and practice; administration of medication, safeguarding patients when they are not given their medications and being open and honest with employers, patients and or families when medications are not administered. Such actions posed a risk to the safety, health and wellbeing of vulnerable patients in Mr Cowan's care. We consider the misconduct serious because the actions of Mr Cowan fell significantly short of what would be expected of a registered nurse'.

The NMC's written submissions in relation to impairment states:

*'**Impairment***

14. The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. 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?"

15. If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.

16. Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.

17. When determining whether the Registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:

1. has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or
2. has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or
3. has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or
4. has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.
18. It is the submission of the NMC that 1, 2 and 3 above can be answered in the affirmative in this case. Dealing with each in turn:

> *(a) This is a case which involves failings in basic nursing skills and practice; administration of medication, safeguarding patients when they are not given their medications and being open and honest with employers, patients and or families when medications are not administered. Those within Mr Cowan's care were vulnerable patients, who depended on him to provide them with the correct medication at the correct time and to make a note of any changes or omissions. Mr Cowan's actions compromised patient safety and has the potential to cause serious harm to patients in his care. The NMC submits Mr Cowan's conduct has in the past put patients at significant risk of unwarranted harm and is liable to do so in the future.*
>
> *(b) The misconduct in this case has the potential to cause damage both now and, in the future, where a registrant fails to deliver appropriate care and document accurately the care that has been provided to patients. Mr Cowan also breached professional duty of candour by failing to raise concerns with management about not administering the medication and failing to inform the patients' families of the errors or reporting the errors on the quality assurance system. Registered professionals occupy a position of trust and must therefore act with integrity and promote a high standard of care at all times. Mr Cowan's failure to do so has brought the profession into disrepute and is likely to bring the profession into disrepute in the future.*

(c) Mr Cowan's failings have also breached fundamental tenets of the profession. Nurses are expected to provide a high standard of care at all times and uphold the reputation of the profession. They also occupy a position of trust both as a nurse and employee. Mr Cowan's misconduct completely contradicts those fundamental tenets of nursing. The failings in this case relate to fundamental 12 nursing practice which raises serious concerns regarding Mr Cowan's professionalism and ability to practise safely as a nurse.

19. Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions:

(i) whether the concern is easily remediable,
(ii) whether it has in fact been remedied and
(iii) whether it is highly unlikely to be repeated.

20. We consider Mr Cowan has displayed limited insight. While he admitted his failings at the local investigation, Mr Cowan has not provided any evidence of reflection, training or any steps taken to address the concerns in this case. Mr Cowan has not shown insight into his failings and the potential effects of this on patient safety and the reputation of the profession.

21. The NMC considers there to be a continuing risk to the public due to Mr Cowan's lack of remediation, limited insight and failure to demonstrate meaningful reflection. There is a significant risk of harm to the public were Mr Cowan allowed to practise without restriction. A finding of impairment is therefore required for the protection of the public.

Public interest

22. In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

23. "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."
24. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.

25. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which hasn't been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

26. However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.

27. Mr Cowan's conduct in failing to deliver appropriate care and documenting care that was provided accurately, calls into question their ability to preserve safety for those in their care. Registered professionals occupy a position of trust and must therefore act with integrity and promote a high standard of care at all times. Mr Cowan's failure to do so has brought the profession into disrepute and is likely to bring the profession into disrepute in the future. His failings have also breached fundamental tenets of the profession. Nurses are expected to provide a high

standard of care at all times and uphold the reputation of the profession. The public expects nurses to practise safely and effectively, including ensuring their conduct, actions and any provided treatment is carried out with the utmost care and attention, with accurate administration of medication and records at all times. This therefore has a negative impact on the reputation of the profession, and, accordingly, has brought the profession into disrepute.

28. We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Mr Cowan's misconduct engages the public interest because members of the public would be concerned to hear of a nurse failing in such basic nursing practice; not keeping accurate records of the care provided to patients and failing to administer the correct medication. Such conduct would severely damage and undermine public confidence in the nursing profession and the NMC, as the regulator'.

The NMC requires the panel to bear in mind its overarching objective to protect 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.

For the reasons outlined, the NMC invited the panel to find Mr Cowan's fitness to practise impaired,

Mr Cowan's local statement dated 16 June 2021, in which he stated:

'… On reflection; my error was caused by not prioritising my tasks, and; although it would have been inappropriate & unprofessional to ignore a resident who was complaining of feeling unwell; I could have advised him that I would return to discuss his concerns as soon as I had finished administering . my medications.

In all my career; I have never before neglected to administer a medication round, and; moving forward; it is a mistake I will never repeat again'. [sic]

Further, Mr Cowan's email response to Witness 2 dated 15 June 2021 stated:

‘Did I not discuss this with you on Friday? I meant to. Sorry if I didn’t.

I don’t know what to say. I got caught up with […] in room 1, then was doing dressings; and I completely lost track of the medications.

In all my years in nursing; that has never happened. I’m really sorry’.

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

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a ‘word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.’

The panel also referred to ‘Making decisions on dishonesty charges and the professional duty of candour’ (Reference: DMA-8, last updated on 6 May 2025) as follows:

*‘**The professional duty of candour***

…We always regard breaches of the duty of candour as very serious, whether or not they are also dishonest.

To comply with the professional duty, nurses, midwives or nursing associates must:

…

- *Act without delay and raise concerns if they experience problems that prevent them from working within the Code. Also act without delay and raise concerns if they or a colleague, or any other problems in the care*

environment, are putting patients at risk of harm. 'Doing nothing' and failing to report concerns is unacceptable….'.

Further, when determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. It determined that Mr Cowan's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Cowan's actions amounted to breaches of the following paragraphs of the Code.

'1.2 make sure you deliver the fundamentals of care effectively.

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues.

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

8.6 share information to identify and reduce risk.

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.

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

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

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 considered that the above paragraphs were engaged in the context of the case.

In relation to charge 1, the panel acknowledged that this charge involved a missed medication round affecting seven patients. The panel considered that such an omission clearly falls short of the standards expected of a registered nurse, particularly given the importance of medication administration in ensuring patient safety. However, taken in isolation, the panel did not consider this failing alone to amount to serious misconduct. The panel noted that the omission was potentially remediable and there was no evidence of harm. Nevertheless, the panel was concerned that Mr Cowan did not provide a valid or acceptable reason for missing the entire round, and that the context surrounding this failing elevated its seriousness.

The panel then turned to charge 2c (failure to enter an incident on RADAR), charge 3a (failure to raise concerns with management), and charge 3c (failure to report the errors on RADAR under the duty of candour). The panel accepted that, individually, charges 2c and 3c might not, on their own reach the threshold of serious misconduct. However, when viewed together, and in combination with the breach of the duty of candour in charge 3a, the panel considered that they demonstrated a pattern of behaviour that significantly departed from the standards expected.

The panel also concluded that charge 3a cannot be separated from charge 1. The failure to escalate, report, or act openly was intrinsically linked to the original omission of the medication round. These failings formed part of the same chain of events and reflected the same underlying conduct.

As such, the panel determined that the proven charges, when viewed collectively, amounted to serious misconduct. This sequence represented a sustained failure to act in accordance with fundamental professional obligations. The panel was particularly concerned by the lack of openness and transparency after the error occurred.

The panel also took into account Mr Cowan's position at the time of the incident. He was working as a Band 6 nurse and Deputy Manager of the Home. Therefore, he was expected to have an elevated understanding of the Home's policies and procedures, including those relating to medication administration, incident reporting, safeguarding, and the duty of candour. There was clear evidence before the panel that Mr Cowan was not only familiar with these policies but actively involved in their implementation. His failure to adhere to them therefore represented a significant departure from the standards expected of a nurse in a senior and trusted managerial role.

For these reasons, the panel concluded that the charges found proved, particularly when considered collectively and in their full context, amounted to serious misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1, last updated on 3 March 2025) in which the following is stated:

> *'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.'*

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. At 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.'*

At 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/their fitness to practise is impaired in the sense that S/He/They:

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 several patients were put at risk of harm as a result of Mr Cowan's misconduct. Although no actual harm occurred, the missed medication round involving seven patients created avoidable risk. Further, Mr Cowan's failures to escalate the error, to report it appropriately, and to uphold the professional duty of candour represented a breach of fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not regard breaches of the duty of candour as extremely serious.

The panel then considered the level of insight demonstrated by Mr Cowan. It acknowledged that, in his local statement dated 16 June 2021, Mr Cowan expressed some early insight, including:

- Accepting personal responsibility for the missed medication round.
- Acknowledging that his error resulted from poor prioritisation.
- Offering an apology.

The panel accepted that this indicated some initial developing insight into how the omission occurred. However, the panel found that this insight was partial and limited. For example, Mr Cowan did not demonstrate:

- A full appreciation of the potential impact of his conduct on patients.
- An understanding of how his actions could undermine trust and confidence among colleagues or the public.
- Meaningful reflection on the seriousness of breaching the duty of candour.
- An adequate explanation of how he would behave differently in the future.

The panel noted that aside from a testimonial from Balmer Care Homes dated 20 January 2022, no further evidence was provided to demonstrate reflection, learning, or sustained development of insight since the incident. Mr Cowan did not provide a recent reflective account and there was no indication of deeper acknowledgment of the consequences of his actions.

The panel considered whether the misconduct was remediable. The panel accepted that failures relating to medication administration and incident reporting are, in principle, capable of remediation. However, the panel also recognised that breaches of the duty of candour can be difficult to remediate, particularly where the conduct reflects an attitudinal issue, specifically, the decision not to report the error. The panel noted:

- The lack of evidence of relevant training.
- No up-to-date reflective work.
- No demonstration of strengthened practice since the incident.
- No meaningful engagement with the regulatory process to show remediation in action.

Given the seriousness of the concerns, particularly relating to the duty of candour, and the limited evidence of remediation, the panel considered that the risk had not been adequately addressed.

The panel considered that the misconduct arose from a combination of poor prioritisation, failure to escalate concerns, and a lack of openness. While the panel acknowledged that the incident occurred over a short time period, it was concerned that these failings were interconnected, that they occurred while Mr Cowan was acting in a senior role (Band 6, Deputy Manager), and that there was limited evidence of meaningful insight or remediation. As such, in the absence of clear, developed insight and remediation, the panel concluded that there is a risk of repetition.

Accordingly, the panel determined that a finding of impairment is necessary on public protection grounds.

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.

Given the seriousness of the concerns, particularly the breach of the duty of candour, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made. Therefore, the panel also finds Mr Cowan's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Cowan's fitness to practise is currently impaired.

Sanction

The panel considered this case very carefully and decided to make a suspension order for a period of six months with a review. The effect of this order is that the NMC register will show that Mr Cowan's registration has been suspended.

Representations on sanction

The panel noted that, in the Notice of Meeting dated 29 September 2025, the NMC had advised Mr Cowan that it would seek the imposition of a conditions of practice order for a period of 12 months if the panel found Mr Cowan's fitness to practise currently impaired.

The NMC's written submissions in relation to sanction state as follows:

> '***Sanction***
>
> *We consider the following sanction is proportionate:*

Conditions of practice order for a period of 12 months.

30. With regard to our sanctions guidance the following aspects have led us to this conclusion:

31. The following mitigating features are present:

- *Mr Cowan accepted the medicine administration failing during the local investigation.*

32. The following aggravating features are present:

- *Mr Cowan's actions put patients at significant risk of harm.*
- *Mr Cowan was in a senior role and breached his professional duty of candour. Taking no further action*

33. The NMC guidance on taking no further action (SAN-3a) states that a panel has a discretion to take no further action after a finding of impairment but will only use that discretion rarely. It is submitted that there are no exceptional features in this case that would warrant taking no further action and given the serious and potentially attitudinal nature of the concerns, this would not be sufficient to protect the public, maintain standards, or maintain confidence in the NMC as a regulator. Caution Order.

34. The NMC guidance on caution orders (SAN-3b) states that a caution order is only appropriate if there is no risk to the public or patients, and the case is at the lower end of the spectrum of impaired fitness to practise. As there is no evidence that Mr Cowan has sufficiently remediated the concerns, it is submitted that there is still a risk of harm to patients.

35. Further, as the conduct alleged is serious and relates to a potential attitudinal concern, which according to the NMC's guidance on seriousness is more difficult to put right, it cannot be said to fall at the lower end of impaired fitness to practice. As such, a caution order would not be sufficient to protect the public or satisfy the public interest considerations.

Conditions of Practice Order

36. The NMC guidance on conditions of practice orders (SAN-3c) states that the key consideration when looking at whether conditions of practice may be appropriate is whether conditions can be put in place that would be sufficient to protect patients and address public confidence in the profession and the NMC.

37. It is a sanction that is more suited to cases where there are clinical concerns and identifiable areas so that the nurse can be supported to return to safe practice.
38. The core of the concerns in this case relate to clinical matters, which our guidance says are easier to put right. This appears to be a single isolated incident in Mr Cowan's career and no further concerns regarding his practice have been raised.

39. The NMC guidance "Can the concern be addressed (FTP-15a)" states issues about safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include medication administration errors such as those in this case.

40. Although Mr Cowans has breached the duty of candour which is a serious concern and can be indicative of an underlying attitudinal concern. In this case, the breach 16 was largely due to his failure to follow processes rather his attitude. Therefore, the concerns in this case can be addressed through reflection, training and supervised practice.

41. We consider that there are measurable and workable conditions which could be formulated to address the risks in this case, protect the public and maintain public confidence in the profession.

42. A conditions of practice order is the most appropriate and proportionate order in this case. We propose the length of the order to be 12 months to allow Mr Cowan sufficient time to obtain employment and demonstrate compliance with the conditions. It will also provide Mr Cowan the opportunity to reflect on his failings and develop his insight.

43. The conditions proposed are as follows:

1. You must limit your nursing practice to one substantive employer which should not be a nursing agency.

2. You must ensure that you are directly supervised by a more senior registered nurse at all times until you have completed updated training in the administration of medication, the safeguarding of patients/residents subjected to medications incidents, reporting and escalating medications concerns and incidents in line with the duty of candour and you are assessed as competent in those areas.

3. You will work with your nursing practice supervisor to create a personal development plan (PDP). Your PDP will address the concerns about your clinical practice with respect to the following:

- *the safe administration of medications*
- *safeguarding patients/residents who have been subjected to medications incidents*
- *the duty of candour and processes relating to reporting and escalating medications incidents and concerns*

You will:

- *send your case officer a copy of your PDP within one month of obtaining a nursing role*
- *meet with your nursing practice supervisor at least monthly to discuss your progress towards achieving the aims set out in your PDP*
- *send your case officer a report from your nursing practice supervisor every month for the first 4 months detailing your progress towards achieving the aims set out in your PDP*
- *a final report should be sent to your case officer at month 5, with a statement from your supervisor that you are competent in the areas set out above*

4. You must maintain a practice log which records and evidences your practice in the areas listed in undertaking 8 above. The practice log will detail every case where you undertake or assist with:

- *medications administration*
- *safeguarding patients/residents subjected to medications incidents*
- *reporting and escalating medications concerns and incidents in line with the duty of candour*

The practice log will:

- *set out the nature of the care given*
- *be signed by your nursing practice supervisor each time*
- *contain feedback from your nursing practice supervisor on how you gave the care*

5. You must submit your practice log to your case officer monthly, alongside the monthly report from your nursing practice supervisor as detailed in undertaking 7.

6. 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

7. 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.

8. You must immediately give a copy of these undertakings 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.

This undertaking concerns nursing, midwifery and nursing associate employment or educational study.

9. You must tell your case officer, within seven days of your becoming aware of:

- *any clinical incident you are involved in*
- *any investigation started against you*
- *any disciplinary proceedings taken against you*

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and progress towards completing these undertakings with:

- *any current or future employer*
- *any educational establishment*
- *any other person(s) involved in your retraining and/or supervision required by these undertakings*

44. The NMC considered whether a suspension order would be appropriate in this case. While Mr Cowan's failings are serious, the concerns in this case do relate mainly to his clinical practice and there is a lesser sanction which can protect the public and maintain public confidence in the profession. The NMC do not consider a striking-off to be appropriate in this case, it is unduly punitive and not proportionate to the risks identified in this case. There is a lesser sanction which could adequately protect the public and satisfy the public interest'.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

Having found Mr Cowan'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 Sanctions Guidance (SG), including 'Available sanction orders' (Reference: SAN-3, last updated on 28 July 2017) and 'Sanctions for particularly serious cases' (Reference: SAN-2, last updated on 6 May 2025). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mr Cowan breached his professional duty of candour.
- Mr Cowan's actions put a number of patients at significant risk of harm, specifically those receiving anticoagulant and diabetes medication.
- The incidents involved vulnerable patients.
- Mr Cowan was in a senior position as Deputy Manager (therefore he had prior knowledge of relevant policies and previous involvement in managing medication errors) and did not escalate the issues that occurred.
- Lack of evidence of insight and remediation in relation to duty of candour.

The panel also took into account the following mitigating features:

- Some remorse and insight in relation to medication errors.
- One testimonial from Balmer Care Homes dated 20 January 2022.
- Mr Cowan's apology and acceptance.

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.

The panel 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 Mr Cowan's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel considered that Mr Cowan's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Cowan's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *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 concluded that there are no practical or workable conditions that could be formulated, given the nature of the charges which also indicate an underlying attitudinal concern. Further, there is lack of any recent and meaningful insight, specifically on the duty of candour issues. For these reasons, the panel concluded that the placing of conditions on Mr Cowan's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour…*

The panel was satisfied that, in this case, the misconduct was not fundamentally incompatible with remaining on the register in light of Mr Cowan's partial insight and acceptance.

The panel went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate and would be going further than is necessary to achieve public protection. Whilst the panel acknowledge that a suspension may have a punitive effect, it would be unduly punitive in Mr Cowan's case to impose a striking-off order.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction. It noted the hardship such an order will inevitably cause Mr Cowan. However, this is outweighed by the public interest in this case.

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

In making its decision, the panel carefully considered the NMC's submissions in relation to the sanction that the NMC was seeking in this case. However, for all the reasons above, the panel considered that a suspension order is the most appropriate and proportionate sanction, particularly given the lack of remediation and potential attitudinal issue.

The panel determined that a suspension order for a period of six months with a review was appropriate in this case to address the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Attendance and engagement at a future NMC hearing.
- A detailed reflective piece that addresses the charges found proved, in particular relating to the impact of the breach of duty of candour.
- Testimonials from previous or current employers (either paid or unpaid).
- Evidence of relevant training relating to the matters found proved in relation to the professional duty of candour.

This will be confirmed to Mr Cowan in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel 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 Mr Cowan's own interests until the suspension sanction takes effect.

The panel accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the written submissions made by the NMC that state as follows:

*'**Interim Order Consideration***

45. If a finding is made that Mr Cowan's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest'.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28-day appeal period and any period which an appeal may be heard.

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

That concludes this determination.