Section 29 Case Meeting

26 January 2021

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

[redacted]

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny & Quality, Professional Standards Authority

In attendance
Christine O'Neill, Legal Advisor, Brodies Solicitors

Observers
Rachael Martin, Team Co-Ordinator, Professional Standards Authority
Seun Fagbohun, Data Administrator, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public
- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly

inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the Court of Session and the statutory time limit for an appeal would expire on 1 February 2021.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on [redacted].

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the panel dated [redacted]
- The Authority's Detailed Case Review
- Legal report by Brodies Solicitors
- Substantive Meeting Bundle Exhibits
- CE Masters Bundle
- The Authority's Section 29 Case Meeting Manual

7.2 The Members and the Legal Advisor were provided with a copy of a response from the NMC to the Authority's Notification of s.29 Meeting.

8. Background

8.1 At the material time the registrant was employed as a [redacted] at a Nursing Home. A referral was made to the NMC in [redacted] following disciplinary proceedings in respect of a series of medication errors occurring in a number of employment settings and which continued despite the registrant being made aware of concerns in his practice.

8.2 On [redacted] the registrant was responsible for the administration of medication to Residents A and B. He had pre-potted the medication and signed the Medication Administration Records (MAR) for the medicines as having been given. The medication

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

had not been given as the residents were asleep and had been left in the treatment room where it was later discovered by another nurse.

8.3 On [redacted], the registrant was responsible for the administration of medication to 16 residents including Trazadone (for the treatment of stress and anxiety) to Resident C and analgesia to Resident D. The registrant's failure to administer the medication to both residents led to a disciplinary hearing on [redacted] following which the registrant was given a verbal warning to remain active for [redacted]. The registrant was also required to attend a counselling session at which correct medication administration policy and practice was re-emphasised.

8.4 On [redacted], the registrant failed to administer spironolactone, used to treat fluid build-up due to heart failure, to Resident E.

8.5 On [redacted] the registrant was responsible for the care of a diabetic patient, Resident F. He recorded a low blood sugar reading and gave the resident a biscuit and some milk after insulin. He did not record his actions on the MAR or clinical notes and therefore there was a risk that another nurse would administer insulin leading to the patient becoming hypoglycemic.

8.6 A further disciplinary hearing was held on [redacted], following which the registrant was dismissed.

8.7 On [redacted], whilst undertaking agency shifts the registrant was responsible for the administration of medication to Resident G, for whom a prescription had been issued for 40mg Oxycodone (an opiate pain killer) twice a day and an additional 10mg Oxycodone once a day in the morning. During the evening medication round, the registrant gave Resident G a dose of 10mg instead of the prescribed 40mg although upon realising his error the following day, he reported the matter and kept Resident G under observation.

8.8 The registrant was suspended from undertaking further work with the recruitment agency following this incident.

8.9 On [redacted], the registrant commenced employment at [redacted]. On [redacted], the registrant failed to administer Apixiban, an anticoagulant used to prevent blood clots and strokes to a resident. On [redacted], the registrant failed to administer Alendronic Acid for the treatment of osteoporosis. [These additional failings were not included in the allegations although were recited in the statement of agreed facts.]

8.10 The repeated medication administration errors were all admitted by the registrant and he accepted the provisional agreement for Consensual Panel Determination (CPD agreement) under which he admitted impairment by reason of misconduct and accepted the proposed sanction of a conditions of practice order for a period of 9 months.

8.11 At the substantive meeting the Panel considered and approved the CPD agreement recommended order for conditions which were imposed for 9 months.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

Were the conditions imposed sufficient?

9.3 The Members considered whether in light of the registrant's repeated medication errors, the terms of the conditions of practice order adequately addressed patient safety concerns. The conditions imposed require the registrant to have supervised practice, but the Members noted that this supervision did not require direct observation of the registrant's practice. The Members also noted that the conditions do not place any restrictions on the registrant's ability to administer medication, nor do they impose any requirement for re-training in this area of practice.

9.4 The Members were concerned by the Panel's decision to impose conditions which did not require direct supervision particularly when administering medication to patients. The Members were concerned that the registrant had continued to make medication administration errors over several work settings and despite concerns being brought to his attention. The Members felt that stricter conditions in terms of supervision were necessary to ensure patient safety and were concerned that the registrant could continue to administer medication without closer supervision.

9.5 The Members also considered whether the Panel should have explored the possibility of imposing a condition which prevented the registrant from administering medication to patients until deemed competent to do so by a supervisor/line manager following his successful competition of a medication management course. The Members considered that such a condition would have further addressed any ongoing patient protection concerns in relation to medication administration.

Procedural irregularities

Under-prosecution

9.6 The Members noted that there were further incidents of medication errors or failures made by the registrant which were referred to in the CE's Bundle which were not included or not fully narrated within the charges or statement of agreed facts. Nor was evidence referring to these further errors placed before the Panel. In total, there were four occasions of either failure to administer medication or a medication error which occurred at the registrant's current place of employment which did not form part of the charges considered by the Panel.

9.7 The Members were concerned that these further errors had the potential to cause harm to patients and had occurred despite further training undertaken by the registrant. The Members concluded that the failure to include these failures/errors in the charges and indeed to fully investigate them amounted to under-prosecution by the NMC.

9.8 The Members considered that had the Panel seen evidence of further errors made by the registrant it might have led it to give further consideration to the final conditions imposed on the registrant's practice. It may well have alerted them to the fact that direct supervision was required or that further training in this area of practice was necessary.

Did the panel give adequate reasons for their decision?

9.9 The Members considered the Panel's reasons for imposing the conditions. The Members noted that the Panel had limited relevant material before it and that, in principle, conditions were an appropriate sanction. Moreover, the Panel did not have evidence of the further medication errors/failures. Nevertheless, the Members felt that there should have been an assessment by the Panel of the registrant's insight and how the conditions would

sufficiently address the risk to patients out of the registrant potentially repeating such errors.

9.10 The Panel failed to note in the decision any independent thoughts it had on the proposed sanction in the CPD agreement and this therefore made it difficult for the Members to determine whether the Panel had reasonably considered all the relevant issues and given sufficient reasons.

Did the panel direct itself to the wrong test?

9.11 The Members noted that paragraph 28 of the provisional CPD agreement states that "any sanction imposed must do no more than is necessary to meet the public interest and must be balanced against the registrant's right to practice [sic] in his chosen career". The Members considered whether the test as formulated by the NMC in the CPD agreement placed undue weight upon the registrant's career aspirations and was not helpful.

9.12 The Members also considered that the CPD agreement, which itself was limited in terms of reasoning, added to the poor reasoning by the Panel and that essentially the Panel approved the CPD agreement without properly considering sanctions.

Conclusion on insufficiency for public protection

9.13 The Members concluded that the panel's decision to accept the CPD agreement and impose these particular conditions for 9-months was insufficient for public protection.

9.14 The Members were concerned that, whilst there was evidence of insight and improvements in the registrant's practice, he continued to make further medication administration errors some of which did not form part of the charges considered at the hearing. Nor were the Panel provided with evidence of these further errors which the Members considered relevant in terms of assisting them in their decision making. The Members were concerned that the registrant still had deficiencies in this area of practice which required closer supervision than that imposed in the conditions.

9.15 The Members were not satisfied that the case had been properly prosecuted or that the Panel had given adequate reasons for accepting the CPD agreement and concluded that such failings were a serious procedural irregularity which meant the Members were unable to determine whether the outcome of the case was insufficient.[2]

10. Referral to court

10.1 Having concluded that the panel's Determination was insufficient for public protection, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to use the Authority's resources proportionately and in the public interest.

10.3 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the Authority should exercise its power under Section 29 and refer this case to the Court of Session.

[2] *Ruscillo* at [72]

	16 February 2021
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Alan Clamp (Chair)	**Dated**

11. Annex A – Definitions

11.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Fitness to Practise Committee of the Nursing & Midwifery Council
The Registrant	[redacted]
The Regulator	Nursing & Midwifery Council
NMC	Nursing & Midwifery Council
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on [redacted]
The Court	Court of Session