Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
14 – 17 February 2022

Virtual Hearing

Name of registrant:	**Gary Cheyne McLellan**
NMC PIN:	02I0588S
Part(s) of the register:	Registered Nurse – Mental Health RNMH – September 2005
Area of registered address:	Glasgow
Type of case:	Misconduct
Panel members:	Mary Hattie (Chair, Registrant member) Marian Robertson (Registrant member) Susan Laycock (Lay member)
Legal Assessor:	Tim Bradbury
Hearings Co-ordinator:	Dilay Bekteshi
Nursing and Midwifery Council:	Represented by Sharmistha Michaels, Case Presenter
Mr McLellan:	Not present and not represented
Facts proved:	1), 2), 3), 4) in its entirety, 5a), 5b), 5d), 6), 7), 8), 9), 10), 11)
Facts not proved:	5c)
Fitness to practise:	Impaired
Sanction:	Striking-off Order
Interim order:	Interim Suspension Order for 18 months

Details of charge:

That you, a registered nurse:

At Gartnavel Royal Hospital: -

1. On 8 April 2017 administered an un-prescribed intra-muscular Pabrinex injection to a patient.

2. On 18 April 2018 during a supervised medication round failed to breathalyse patient 1 and/or patient 2 prior to administering Disulfiram.

At Greenfield Park Nursing Home on 14 December 2019: -

3. Failed to count the controlled drugs during handover.

4. Administered the following controlled drugs without a second checker present:

    a) Morphine Sulfate to resident A.
    b) Morphine Sulfate to resident B.
    c) Temazepam to resident C.
    d) Tramadol to resident D.

5. Requested Colleague A to countersign the administrations at '4' as follows:

    a) The Medicines Administration Record and/or the controlled drugs register for resident A.
    b) The Medicines Administration Record and/or the controlled drugs register for resident B.

c) The Medicines Administration Record and/or the controlled drugs register for resident C.
d) The Medicines Administration Record and/or the controlled drugs register for resident D.

6. Your request at ‘5’ ‘a)’ and/or ‘b)’ and or ‘c)’ and or ‘d)’ was dishonest in the you knew that Colleague A had not witnessed the administration of any of the controlled drugs.

7. The dose of Morphine Sulfate to resident A at ‘4a)’ was a second dose.

8. Signed the Medicines Administration Record for the 8pm dose at ‘4a)’ but administered it sometime around 10pm to 11pm.

9. The dose of Morphine Sulfate to resident B at ‘4b)’ was a second dose.

10. Signed the Medicines Administration Record for the 8pm dose at ‘4b)’ but administered it sometime around 10pm to 11pm.

11. Failed to record the administration of Temazepam to resident C at ‘4c)’ in the controlled drug register.

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr McLellan was not in attendance and that the Notice of Hearing letter had been sent to Mr McLellan's registered email address on 10 January 2022.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and the virtual hearing link and, amongst other things, information about Mr McLellan's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

The panel accepted the advice of the legal assessor.

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

Decision and reasons on proceeding in the absence of Mr McLellan

The panel next considered whether it should proceed in the absence of Mr McLellan. The panel had regard to Rule 21(2), which states:

> *'**21.—** (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—*

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.'

Ms Michaels invited the panel to continue in the absence of Mr McLellan on the basis that he had voluntarily absented himself.

Ms Michaels referred the panel to the documentation from Mr McLellan which included a telephone message from Mr McLellan to his NMC case officer on 26 July 2021 which states the following:

"I received a telephone e message from Reg [sic]*. I called the Registrant back and he informed me that he will not be attending/participating in the IO hearing and he does not have anything further to add.*

He informed me that he would not be participating he has nothing further to add and will not be engaging with the NMC any further. I did try to explain other ways of dealing with the case (VR, CPD etc) as he said he isn't working and does not intend to return to nursing but he was adamant that he did not want to engage and will not be providing any response.

I did explain that the NMC would proceed with the case and still send out correspondence to him he said ok. I asked again if he was sure he did not want to engage and he said no he would not be engaging."

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of Mr McLellan under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R.* v *Jones (Anthony William)* (No.2) [2002] UKHL 5. The panel further noted the case of *R (on the application of Raheem) v Nursing and Midwifery Council* [2010] EWHC 2549 (Admin) and the ruling of Mr Justice Holman that:

'...reference by committees or tribunals such as this, or indeed judges, to exercising the discretion to proceed in the person's absence "with the utmost caution" *is much more than mere lip service to a phrase used by Lord Bingham of Cornhill. If it is the law that in this sort of situation a committee or tribunal should exercise its discretion* "with the utmost care and caution"*, it is extremely important that the committee or tribunal in question demonstrates by its language (even though, of course, it need not use those precise words) that it appreciates that the discretion which it is exercising is one that requires to be exercised with that degree of care and caution.'*

The panel has decided to proceed in the absence of Mr McLellan. In reaching this decision, the panel has considered the submissions of Ms Michaels, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr McLellan;

- On 26 July 2021 Mr McLellan has informed the NMC that he will not be attending the hearing and will not be engaging with the NMC any further;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Two witnesses are due to attend today to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2017 and 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr McLellan in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr McLellan's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Michaels under Rule 31 to allow the hearsay evidence of Witness 1, Witness 2, Witness 3 and Witness 4 into evidence. She told the panel that their evidence relates solely to Charge 1 and 2. She also informed the panel that the evidence relates to an earlier reopened case in regard to earlier drug errors. Ms Michaels further told the panel that Mr McLellan responded to the allegations reflected in Charges 1 and 2, and produced a statement which was sent to the original referral in 2017. A further statement was produced in the Registrant's Response Bundle by UNISON on Mr McLellan's behalf.

Ms Michaels invited the panel to admit the four written statements as hearsay evidence. She told the panel that written statements exhibit contemporaneous statements that were taken at the time of the incident in 2017. Mr McLellan had not raised any objections to the written statements being read into evidence. Ms Michaels submitted that Witness 1's, Witness 2's, Witness 3's and Witness 4's evidence was relevant, and that no unfairness would be caused to Mr McLellan if the statements were to be admitted into evidence as hearsay.

Witness 1

Ms Michaels told the panel that Witness 1 was the Professional Nurse Lead for Addiction Services at NHS Greater Glasgow and Clyde (NHS GGC). She told the panel that Witness 1 was not involved in the initial investigation of the alleged drug error in 2017, but that she was involved in the disciplinary hearing. Ms Michaels told the panel that Witness 1 talks about the Personal Development Plan (PDP), the incident in 2018 and exhibits a contemporaneous statement produced by Mr McLellan in the 2017 incident.

Witness 2

Ms Michaels informed the panel that Witness 2 was the Addiction Nurse at Gartnavel Royal Hospital (the Hospital) where Mr McLellan worked at the time. She informed the panel that on 8 April 2017, Witness 2 was the nurse in charge of the day of the clinical incident when Mr McLellan allegedly administered an un-prescribed intra-muscular Pabrinex injection to a patient. Witness 2 talks about what happened following the incident on 8 April 2017 and the protocols that were followed subsequently. Ms Michaels submitted that Witness 2's statement does not contradict what was said by Mr McLellan in his own statement at that time.

Witness 3

Ms Michaels informed the panel that Witness 3 was the Senior Charge Nurse at the Hospital, and that their responsibilities included 24-hour management and running of the inpatient unit and staff, for a drug or alcohol addiction unit. She informed the panel that Witness 3 was the manager on call on 8 April 2017. Witness 3 talks about the call they had received from Witness 2 on the day of the incident and that Witness 3 prepared a contemporaneous statement exhibited in their statement. Ms Michaels submitted that the statement of Witness 3 does not contradict what was said by Mr McLellan.

Witness 4

Ms Michaels informed the panel that Witness 4 was the HR Advisor based at West Glasgow Ambulatory Care Hospital and that their responsibilities include providing support to disciplinary and grievance procedures and advising on employment policies. She informed the panel that Witness 4 was involved in the investigation into the incident on 8 April 2017, provided HR support, attended investigation meetings with witnesses and Mr McLellan, took notes and transcribed them.

Ms Michaels submitted that Mr McLellan had received notice of the hearing, the bundles and witness statements that the NMC will rely on. She told the panel that Mr McLellan had had an opportunity to respond. She referred the panel to an email dated 3 February 2022, with attachments of the final hearing bundles containing witness statements of Witness 1, Witness 2, Witness 3 and Witness 4. Ms Michaels told the panel that Mr McLellan has not raised any objections and has not provided any response.

The panel accepted the advice of the legal assessor. Rule 31 of the Rules provides that, so far as it is "fair and relevant", a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered that as Mr McLellan had been provided with a copy of Witness 1's, Witness 2's, Witness 3's and Witness 4's statements on 3 February 2022 and, as the panel had already determined that Mr McLellan had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine any witness in any case. The panel noted that the statements and exhibits produced documents and concerned largely undisputed factual evidence. It considered that the evidence was relevant. The panel also noted that Mr McLellan had raised no objections to the statements being read into evidence. The panel therefore considered that no unfairness would be caused to Mr McLellan by reading Witness 1's, Witness 2's, Witness 3's and Witness 4's statements into evidence.

The panel therefore determined to accept the NMC's application for Witness 1's, Witness 2's, Witness 3's and Witness 4's statements to be read into evidence as hearsay, but would give such weight as it deemed appropriate once the panel had heard and evaluated all the evidence before it.

Background

The NMC received a referral regarding Mr McLellan's fitness to practice on 23 January 2020. The referral came from the Senior Home Manager of Greenfield Park Nursing Home ('the Home'). At the time of the concerns raised, in the referral, Mr McLellan was working as a nurse at the Home.

The concerns surrounding Mr McLellan's practise are in relation to controlled drug errors and administration involving four residents at the Home, which took place during a night shift on 14 – 15 December 2019, it is alleged that Mr McLellan failed to follow the correct procedure for administering controlled drugs to residents A, B, C and D in that Mr McLellan allegedly:

- administered controlled drugs to resident A and resident B without checking the controlled drugs register, resulting in an additional dose being given;

- failed to ensure a second nurse witnessed the administration of controlled drugs to residents A, B, C and D.

- asked a second nurse to counter-sign the administration of controlled drugs to residents A and B despite that nurse not being present when the drugs were given;

- failed to record the administration of a controlled drug to resident C in the controlled drugs register.

Following the incident, the Senior Home Manager at the Home carried out an internal investigation. Mr McLellan failed to engage with the investigation. As a result, Mr McLellan was called to a probationary review meeting on 24 December 2019. Mr

McLellan was dismissed with notice, having failed his probation and having shown no insight regarding the seriousness of the controlled drug administration errors.
The NMC are also considering an earlier, reopened case in Mr McLellan's name in regard to earlier drug errors at the Hospital.

Facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case. The written statements of Witness 1, Witness 2, Witness 3 and Witness 4 were admitted into evidence as hearsay. The panel heard submissions made by Ms Michaels on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mr McLellan.

The panel accepted the advice of the legal assessor, which included reference to the cases of *Ivey v Genting Casinos Ltd* [2017] UKSC 67 and *Uddin v GMC* [2012] EWHC 1763 (Admin).

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Mr 1: Senior Home Manager of the Home.

- Colleague A: Staff Nurse at the Home.

Decision on the findings on facts and reasons

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

Charge 1)

At Gartnavel Royal Hospital:-

1. On 8 April 2017 administered an un-prescribed intra-muscular Pabrinex injection to a patient.

This charge is found proved.

In reaching this decision, the panel took into account Mr McLellan's statement and Witness 2's statement.

The panel considered Mr McLellan's statement in which he admitted administering Pabrinex to the patient and subsequently realising that the patient was not "*written up"* for this medication.

The panel also considered the statement of Witness 2 which states: *"Gary had seen the patient and had tried to be quick as it was a Saturday morning, and the patient had expressed that he had plans that day. Gary had realised that the Pabrinex had not been prescribed when he was filling out the patient notes, after he had finished the treatment and let the patient go home. He informed me of this without delay and I put into place the relevant protocol and procedures, such as informing the on call Senior Nurse, and on call Doctor."*

The panel therefore finds Charge 1 proved.

Charge 2)

At Gartnavel Royal Hospital: -

2. On 18 April 2018 during a supervised medication round failed to breathalyse patient 1 and/or patient 2 prior to administering Disulfiram.

This charge is found proved.

In reaching this decision, the panel took into account the Registrant's Response Bundle and the statement of Witness 3.

The panel noted that in the Registrant's Response Bundle that Mr McLellan *"forgot to breathalyse the patient prior to medication."*

The panel also considered the statement of Witness 3 which states: ***"****I was informed as part of the handover that Gary had to be prompted to breathalyse patients prior to administering Disulfiram. He was prompted by a Senior Charge Nurse…The patients are breathalysed upon entering the day unit…However, they might be at the unit for hours, coming and going, before being administered Disulfiram. They might have consumed alcohol in this time. Therefore it would be logical that patients should be breathalysed directly before being administered with Disulfiram, as it can be very serious if it interacts with alcohol. "*

The panel determined that it was standard practice to breathalyse patients prior to administering disulfiram.

The panel therefore find Charge 2 proved.

Charge 3)

At Greenfield Park Nursing Home on 14 December 2019: -

3. Failed to count the controlled drugs during handover.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 1, Colleague A, the Home's Controlled Drugs Procedure, namely 2(e) and Mr McLellan's contemporaneous record.

The panel considered the evidence of Mr 1 who describes the investigation into the incidents on 14 December 2019 and comments on duty, awareness and seriousness. The panel also had sight of the Home's Controlled Drugs Procedure which states at section 2(e): "*Balances of each Controlled Drug should be checked and recorded once daily; it is recommended that this check is carried out at the end of each shift after the handover between colleagues with responsibility for medicines management in the Home."* Mr 1 confirmed that this is also "*good practice*".

Mr 1 confirmed that Mr McLellan admitted that he had not counted the controlled drugs register at the start of the shift, as required under the policy.

The panel noted that the Home's Controlled Drugs Procedure was not specific as to who is responsible for counting the controlled drugs during handover, but the panel concluded that the policy was consistent with and reflected what is the well-established practice within the nursing profession in regard to the checking of controlled drugs at handover times. In these circumstances, Mr McLellan had the responsibility to be present at the count of the controlled drugs with the outgoing staff nurse. The panel also noted that there is no indication in the controlled drugs register that Mr McLellan had signed for the 20:30 check for the controlled drugs.

The panel therefore find Charge 3 proved.

Charge 4)

At Greenfield Park Nursing Home on 14 December 2019: -

4. Administered the following controlled drugs without a second checker present:

    a) Morphine Sulfate to resident A.
    b) Morphine Sulfate to resident B.
    c) Temazepam to resident C.
    d) Tramadol to resident D.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Mr 1, Mr McLellan's statement and the Home's Controlled Drugs Procedure.

The panel noted that the Controlled Drugs Procedure confirms that the controlled drug register must be completed when drugs are administered and both documents must be counter-signed by the person that actually witnesses the administration of the drug.

The panel considered the evidence of Colleague A who stated that Mr McLellan informed her that Residents A and B had not had their 20:00 dose of Morphine Sulfate as the Medicines Administration Record (MAR) charts had not been signed. After confirming with the manager that the drugs could be given, Colleague A relayed this to Mr McLellan. Mr McLellan had then informed Colleague A that he had already administered them. Colleague A reminded him that this was not the correct process (as a second checker/signature was required) but agreed to sign the documentation if the drug count was correct in the controlled drugs register.

Mr McLellan in his contemporaneous statement said, "*I told [Colleague A] I had already given the medication."*
The panel considered the evidence of Mr 1 who stated that upon reviewing the documentation, he discovered that Mr McLellan had failed to sign the controlled drugs register after administering a dose of Temazepam to resident C. Mr McLellan confirmed in his contemporaneous statement that he gave the Temazepam to resident C without a second checker.

Mr 1 also told the panel that he discovered (after reviewing the documentation) a further incident had occurred during the shift whereby Mr McLellan had administered controlled drug, Tramadol, to resident D without a second check. On the controlled drugs register for resident D, Colleague A had counter signed as she was satisfied that the drug had been given, even though she was not present at the time. This was in breach of the Controlled Drugs Procedure as Mr McLellan should have asked a nurse to witness the administration of the drug before signing. The panel also noted that Mr McLellan confirmed in his contemporaneous statement that he administered the drugs to residents without a second checker.

The panel therefore find Charge 4 proved in its entirety.

Charge 5)

At Greenfield Park Nursing Home on 14 December 2019: -

5. Requested Colleague A to countersign the administrations at '4' as follows:

    a) The Medicines Administration Record and/or the controlled drugs register for resident A.
    b) The Medicines Administration Record and/or the controlled drugs register for resident B.

c) The Medicines Administration Record and/or the controlled drugs register for resident C.
d) The Medicines Administration Record and/or the controlled drugs register for resident D.

This charge is found proved for a), b) and d).

In reaching this decision, the panel took into account the statement of Mr McLellan, Colleague A's evidence, her contemporaneous statement and the controlled drugs register for resident C.

The panel considered the statement of Mr McLellan which states: "*I went next door to ask the nurse to sign off the medication... I explained the situation and asked if she can co-sign…*"

The panel also considered the statement of Colleague A which states: *"At this point in time the Registrant said he had already given them. I said to the Registrant that he knows he was not supposed to give these drugs without following the correct process; but as he said he had already given the drugs we both agreed I would sign the MAR/controlled drugs book if the drug count was right."*

The panel also had sight of the contemporaneous statement from Colleague A which states: "*Gary asked me to sign the CD book as he had already administered the medication at 22:00 I checked to make sure the MAR sheets had not been signed for 20:00 and then spoke to Gary saying we are not supposed to give CDs without 2 people checking them as Gary had already signed the MAR sheet I signed under his initials.*"

The panel also had regard to the controlled drug record for resident C which records *"signed for on MARS as given"* with Mr 1's initials and another set of initials.

The panel considered the evidence of Mr 1 that upon reviewing the documentation, he discovered that Mr McLellan failed to sign the controlled drug register after

administering Temazepam to resident C. However, the panel did not see a copy of the MARs in respect of resident C. Accordingly, there was no evidence before the panel to suggest that Colleague A had signed the MARs or that Mr McLellan had requested her to do so. Therefore, Charge 5c) is found not proved.

The panel therefore finds Charge 5a), b) and d) proved.

Charge 6)

At Greenfield Park Nursing Home on 14 December 2019: -

6. Your request at '5' 'a)' and/or 'b)' and or 'd)' was dishonest in the you knew that Colleague A had not witnessed the administration of any of the controlled drugs.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Mr 1, Mr McLellan's statement and the Controlled Drugs Policy.

The Controlled Drugs Procedure states that administration must be witnessed by a second nurse / carer and the controlled drugs register must then be completed straight away "without delay."

The panel considered the evidence of Colleague A who stated that she and Mr McLellan had discussed the correct procedure and "*both agreed*" that she would counter-sign the patient records.

The panel also noted that Mr 1 confirmed in his evidence that Mr McLellan had received training on administration of medicines and controlled drugs as part of his induction, and that in December 2019 following a medication error all staff had received the policy and supervision reinforcing the correct procedure for administration of medication.

Therefore, the panel determined that Mr McLellan had received appropriate training and was aware of the administration of medicines policy and controlled drugs procedure. The panel further determined that he would have known at the time that he requested Colleague A to counter sign the MAR and/or controlled drugs register that Colleague A had not witnessed the drug administrations.

In these circumstances, the panel concluded that Mr McLellan had deliberately sought to create a misleading record, namely a record that the administration of controlled drugs to a resident(s) had been witnessed when they had not.

The panel determined that by the standards of ordinary people, Mr McLellan's actions would be regarded as dishonest.

The panel therefore find Charge 6 proved.

Charge 7)

At Greenfield Park Nursing Home on 14 December 2019: -

7. The dose of Morphine Sulfate to resident A at '4a)' was a second dose.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Mr 1 and the Controlled Drug Sheet for Resident A.

The panel considered the Controlled Drugs Register for resident A which showed that Morphine Sulfate was administered at *"20:00*". It noted that Mr 1 confirmed that having reviewed the controlled drug register and the MARs sheet and undertaken an investigation including taking statements from the staff involved, he found that staff had administered the Morphine Sulfate at 20:00 to resident A. They had signed the

controlled drugs register but not the MAR sheets. Mr 1 confirmed that between 22:00 and 23:00 Mr McLellan noted that the 20:00 dose of Morphine Sulfate for resident A had not been signed for on the MAR charts. Mr McLellan therefore administered a second dose of Morphine Sulfate to resident A. Mr McLellan then signed the 20:00 entry on the MAR chart to confirm he had given this.

This is confirmed in the statement of Colleague A who stated that Mr McLellan advised her he had administered Morphine Sulfate to resident A believing the 20:00 dose had been missed, but that when going to sign the controlled drug register, she discovered that it had been signed for.

The panel therefore finds Charge 7 proved.

Charge 8)

At Greenfield Park Nursing Home on 14 December 2019: -

8. Signed the Medicines Administration Record for the 8pm dose at '4a)' but administered it sometime around 10pm to 11pm.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, the Controlled Drugs Register and the MARs chart for resident A.

The panel determined that there is sufficient evidence to suggest that Mr McLellan had signed the MARs at 8pm, but administered it sometime around 22:00 to 23:00. It noted that there was no direct evidence as to precisely the time at which the drugs were administered, but Mr 1's statement states the following: "*When I attended the Home on the morning of 15 December 2019, [Colleague A] explained that she had been called by the Registrant to countersign controlled drugs for two residents…She realised an*

additional dose had been given in error by the Registrant at approximately 22:00 – 23:00 to Resident A and Resident B before realising there had been an error."

The panel considered the contemporaneous statement of Colleague A which states: "*At 23:30 I was asked to go around to check controlled drugs with staff nurse [Mr McLellan] in Roselea unit. Gary asked me sign the CD book as he had already administered the medication at 22:00."*

The panel also considered the Controlled Drugs Register for residents B, C and D had their controlled drugs recorded as being administered at 22:00. The panel determined that it is reasonable to assume that Resident A's controlled drug was administered at around 22:00 to 23:00. It also noted that Mr McLellan was on a night shift and that the night medication round was scheduled for 22:00. It therefore determined that it is more likely than not that Mr McLellan had administered the controlled drug sometime around 22:00 to 23:00.

The panel therefore find Charge 8 proved.

Charge 9)

At Greenfield Park Nursing Home on 14 December 2019: -

9. The dose of Morphine Sulfate to resident B at '4b)' was a second dose.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Mr 1, the controlled drug sheet for resident B.

The panel considered the controlled drugs register for resident B and that Morphine Sulfate was administered at 20:00. It noted that Mr 1 confirmed that having reviewed the controlled drug register and the MARs sheet and undertaken an investigation including

taking statements from the staff involved, he found that staff had administered the Morphine Sulfate at 20:00 to resident B. They had signed the controlled drugs register but not the MAR sheets. Mr 1 confirmed that between 22:00 and 23:00 Mr McLellan noted that the 20:00 dose of Morphine Sulfate for resident B had not been signed for on the MAR charts. Mr McLellan therefore administered a second dose of Morphine Sulfate to Resident B. Mr McLellan then signed the 20:00 entry on the MAR chart to confirm he had given these.

This is confirmed in the statement of Colleague A who stated that Mr McLellan advised her he had administered Morphine Sulfate to resident B believing the 20:00 dose had been missed, but that when going to sign the controlled drug register, she discovered that it had been signed for.

The panel therefore finds Charge 9 proved.

Charge 10)

At Greenfield Park Nursing Home on 14 December 2019: -

10. Signed the Medicines Administration Record for the 8pm dose at ‘4b)’ but administered it sometime around 10pm to 11pm.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, the controlled drugs register and the MAR chart for resident B.

The panel considered that the controlled drugs register for residents B, C and D had their controlled drugs as being administered at 22:00. It also noted that Mr McLellan was on a night shift and that the night medication round is scheduled for 22:00. It

therefore determined that it is more likely than not that Mr McLellan had administered the controlled drug sometime around 22:00 to 23:00.

The panel noted that there was no direct evidence as to precisely the time at which the drugs were administered, but it noted the following from Mr 1's statement which states the following: "*When I attended the Home on the morning of 15 December 2019, [Colleague A] explained that she had been called by the Registrant to countersign controlled drugs for two residents…She realised an additional dose had been given in error by the Registrant at approximately 22:00 – 23:00 to Resident A and Resident B before realising there had been an error."*

The panel considered the contemporaneous statement of Colleague A which states: "*At 23:30 I was asked to go around to check controlled drugs with staff nurse [Mr McLellan] in Roselea unit. Gary asked me sign the CD book as he had already administered the medication at 22:00."*

The panel therefore find Charge 10 proved.

Charge 11)

At Greenfield Park Nursing Home on 14 December 2019: -

11. Failed to record the administration of Temazepam to resident C at '4c)' in the controlled drug register.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 1 and the controlled drugs register for resident C.

The panel determined that that Mr 1 was clear in his statement and was a credible witness. It considered the following from Mr 1's statement: "*I discovered a further incident had taken place during this shift whereby the Registrant had administered a controlled drug, Temazepam to Resident C without recording this in the controlled drugs register."* The panel also had regard to the controlled drugs register for resident C exhibited by Mr 1 which indicates that it was signed on the MARs chart *"as given*." But Mr McLellan had not signed or recorded this on the controlled drugs register. The panel also noted that Mr McLellan was the nurse in charge on the night shift and undertook the drug round.

The panel therefore find Charge 11 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 McLellan's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct and impairment

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

Ms Michaels invited the panel to take the view that the facts found proved amount to a breach of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code)*. She directed the panel to specific paragraphs and standards and identified where, in the NMC's view, Mr McLellan's actions amounted to a breach of those standards.

Ms Michaels submitted that Mr McLellan's actions fell significantly short of the standards expected of a registered nurse, given the history of drug errors and failure to comply with the relevant policy and procedures. She submitted that these failings are not isolated events and took place over a sustained period, and despite, for a period of time, being under a PDP as a result of the error in 2017. She told the panel that no harm was caused to residents, however there was potential for serious harm. This coupled with the finding of dishonesty by asking his colleague to retrospectively sign the MARs sheets and the controlled drugs register could only amount to misconduct. Ms Michaels further submitted that Mr McLellan failed to comply with the Home's administration and medicines policy and the controlled drugs procedure, despite having received training and supervision.

Ms Michaels 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Michaels submitted there is no evidence to demonstrate insight, remorse or remediation, and therefore there is a risk of repetition. She submitted that Mr McLellan has not positively engaged with the proceedings following the 2019 incident. She told the panel that Mr 1 in his evidence indicated that at the time of the incident in 2019, Mr McLellan had shown little concern for the welfare of the residents or any insight. She submitted that Mr McLellan acted dishonestly, and that there is also a risk of repetition of this dishonesty. Ms Michaels concluded that a finding of current impairment is warranted on the basis of both public protection and the public interest.

Ms Michaels told the panel that whilst Mr McLellan did provide a response and did cooperate with the original investigation in 2017 and 2018, he has not engaged since July 2021 when he indicated that he will not be engaging in the NMC proceedings. In light of these circumstances, Ms Michaels invited the panel to find that Mr McLellan is currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *PSA v Uppal* [2015] EWHC 1304 (Admin).

Decision and reasons on misconduct

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

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

> ***'8 As a registered nurse, midwife or specialist community public health nurse, you must act to identify and minimise the risk to***

patients and clients

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

10 Keep clear and accurate records relevant to your practice

10.1 *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

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 all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

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

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

20 Uphold the reputation of your profession at all times

20.2 *act with honesty and integrity at all times…*

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

The panel considered that the failure to follow the correct procedure in administering controlled drugs, and dishonesty in asking Colleague A to counter-sign administration of

drugs she had not witnessed gave rise to a potential risk to patients. Also of concern to the panel were the number and frequency of Mr McLellan's errors and omissions which occurred over a two-year period in respect of medicines administration and recording, despite having received training and supervision.

The panel also bore in mind Mr McLellan's dishonesty. The panel considered that Mr McLellan's request to Colleague A to countersign the administration for MARs and the controlled drugs register for residents A, B and D she had not witnessed, was very serious as it was intended to conceal the fact that he had failed to comply with the Home's policy for controlled drugs administration which was in place to ensure safety of the residents.

The panel therefore found that Mr McLellan's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, 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 *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) 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.'*

In light of the findings set out in relation to misconduct, the panel considered that all four limbs of the test set out by Dame Janet Smith in the Fifth Report from Shipman are engaged in this case. These were serious failings which related to basic nursing care and basic standards that would have been expected from a registered nurse. In light of this, the panel considered that Mr McLellan's actions clearly brought the profession into disrepute and put residents at risk of harm.

In considering whether Mr McLellan was liable to act in such a way in the future. The panel considered that Mr McLellan's failings in relation to the medicines administration and record-keeping, notwithstanding the fact that these were numerous, were in themselves remediable. However, the panel did not consider that there was any evidence which indicated that these failings had been remedied. There was no evidence to suggest that Mr McLellan had undertaken any training or any other steps which indicated that his failings were unlikely to be repeated.

The panel considered that dishonesty, whilst being difficult to remediate, is capable of remediation. In this case the dishonesty was aggravated by the fact that Mr McLellan sought to conceal his failure to follow procedures resulting in placing residents at a risk of harm. The panel bore in mind that Mr McLellan had not provided a reflective account to indicate that he understood the impact of his actions, that he was remorseful or that he had remedied his dishonesty. Mr McLellan had failed to recognise the impact that his dishonesty had on residents, members of staff and the reputation of the nursing profession.

Due to the lack of remediation, insight or remorse on Mr McLellan's part, the panel concluded that there was a real risk of repetition of the failings in this case. The panel considered that Mr McLellan was liable to put patients at risk of harm, bring the profession into disrepute, breach fundamental tenets of the profession and behave dishonestly, in the future. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that, in this case, a finding of impairment on public interest grounds is necessary in order to maintain public confidence in the nursing profession and in the NMC as regulator and in order to declare and uphold proper standards of conduct and performance.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr McLellan off the register. The effect of this order is that the NMC register will show that Mr McLellan has been struck-off the register.

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 Michaels, on behalf of the NMC, outlined the sanction bid for a suspension order. She informed the panel that Mr McLellan is currently under an interim suspension order imposed on 28 July 2021 for a period of 18 months. She outlined aggravating and mitigating factors for the panel to consider.

Ms Michaels submitted that given the risk of repetition in this case, taking no further action would not be appropriate. She also submitted that a caution order would not be appropriate, as this would not restrict Mr McLellan's practice.

Ms Michaels submitted that a conditions of practice order would not be appropriate, workable or practicable, given that Mr McLellan's lack of engagement with the NMC, there is no evidence before the panel to suggest that Mr McLellan will be willing to comply with any conditions imposed. She further submitted that conditions of practice order would not sufficiently address the public interest and public protection considerations in this case.

Ms Michaels invited the panel to impose a suspension order for a period of 12 months. She submitted that a suspension order would adequately protect the public and maintain public confidence in the profession.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct over a period of time, despite having received training and support in 2018 and 2019.
- Mr McLellan's refusal to participate in a local investigation in relation to the incidents on 14 December 2019.
- Placed residents at a risk of harm.

- Failed to recognise his impact that dishonesty had had on residents, members of staff as well as the reputation of the profession.
- The only recent engagement by Mr McLellan was on 26 July 2021 when he confirmed that he will not be engaging with the NMC any further.
- Lack of insight, remediation or remorse into failings

The panel also took into account the following mitigating features:

- Mr McLellan provided a response to the NMC in relation to Charges 1 and 2. There was some acceptance of the earlier concerns.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case, Mr McLellan's lack of insight and remorse and given the fact that the panel have identified a risk of repetition. The panel determined that taking no further action would not protect the public and it would not satisfy the wider public interest.

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 Mr McLellan'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 determined that Mr McLellan's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel determined that Mr McLellan's misconduct was at the higher end of the spectrum of impaired fitness to practise, given the widespread nature of the failings and the dishonesty in this case. The panel therefore determined that imposing a caution order would not protect the public and it would not satisfy the wider public interest.

The panel next considered whether to impose a conditions of practice order. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, which states that conditions of practice may be appropriate where some or all of the following factors are apparent:

- *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*
- *…*
- *potential and willingness to respond positively to retraining*
- *…*
- *…*
- *the conditions will protect patients during the period they are in force*
- *it is possible to formulate conditions and to make provision as to how conditions will be monitored"*

The panel bore in mind the dishonesty found proved in this case, and Mr McLellan's lack of insight and remorse. Whilst it was possible to identify areas of Mr McLellan's practice that would be in need of assessment and retraining, the panel did not consider that it was possible to identify practical and workable conditions that could be put in place, given Mr McLellan's lack of engagement with the NMC and a clear statement that he does not intend to engage any further. The panel also considered that dishonesty by its nature was not something which could be addressed through conditions of practice. Furthermore, given the seriousness of the failings in this case, the panel determined that a conditions of practice order would not protect the public, nor would it satisfy the wider public interest in this case.

The panel went on to consider whether to impose a suspension order. The panel had regard to the SG which states such an order may be appropriate in the following circumstances:

- *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 considered that this was not a case of a single instance of misconduct, but one where Mr McLellan's failings were numerous and widespread, and occurred over a period of time. The panel was not satisfied that Mr McLellan has developed any insight into his failings, and considered that this was aggravated by the fact that he has not positively engaged with the NMC. The panel considered that there was evidence of attitudinal problems on Mr McLellan's part due to his lack of engagement with the Home's investigation and the NMC. The panel acknowledged that there was no evidence of repetition since the incident in 2019. However, the panel did not have any evidence as to whether Mr McLellan has been working as a registered nurse since this time. Mr McLellan did not have insight into his conduct and the panel considered that he does pose a significant risk of repeating his behaviour.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr McLellan's actions, coupled with a complete absence of any evidence of insight or attempts to remediate, is fundamentally incompatible with Mr McLellan remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

The panel next considered whether to impose a striking-off order. The panel had regard to the SG which states that this sanction would be appropriate where the behaviour is

fundamentally incompatible with being a registered professional, which may involve any of the following factors:

- *A serious departure from the relevant professional standards as set out in key standards, guidance and advice.*
- *Doing harm to others or behaving in such a way that could foreseeably result in harm to others…*
- *…*
- *...*
- *…*
- *Dishonesty, especially where persistent or covered up…*
- *Persistent lack of insight into seriousness of actions or consequences.*

The panel considered that Mr McLellan's numerous, serious and widespread failings and dishonesty demonstrate a significant departure from the professional standards expected of a registered nurse. Mr McLellan's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr McLellan's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel also had regard to the case of *Parkinson v NMC*, in which the following was stated:

> *"A nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. A nurse who has acted dishonestly, who does not appear before the Panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct criticised was dishonest, and an undertaking that there will be no repetition,*

effectively forfeits the small chance of persuading the Panel to adopt a lenient or merciful outcome and to suspend for a period rather than direct erasure."

The panel noted that Mr McLellan had chosen not to attend this hearing. Whilst he had responded to the NMC on 26 July 2021, he has not demonstrated any insight or remorse into his conduct, and he indicated at this time that he will not be participating with the proceedings. Therefore, the panel considered that Mr McLellan had forfeited his opportunity to persuade the panel to adopt a more lenient option other than removal from the register.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr McLellan's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to protect the public and 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.

Interim order

As the striking-off 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 Mr McLellan's own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

The panel considered the submissions made by Ms Michaels, on behalf of the NMC, that an interim suspension order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the striking-off order 28 days after Mr McLellan is sent the decision of this hearing in writing.

That concludes this determination.