Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
18-25 July 2022

Virtual Hearing

Name of registrant:	Eileen Kathryn Watson
NMC PIN:	79D1090E
Part(s) of the register:	Registered Nurse RN 2 - Adult – 14 May 1981 RN 1 – Adult – 29 September 1997
Relevant Location:	Halifax and Huddersfield
Type of case:	Misconduct
Panel members:	Carolyn Tetlow (Chair, Lay member) Richard Bayly (Lay member) Sharon Peat (Registrant member)
Legal Assessor:	Richard Tyson
Hearings Coordinator:	Roshani Wanigasinghe
Nursing and Midwifery Council:	Represented by Megan Millar, Case Presenter
Mrs Watson:	Not present and unrepresented
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order – 18 months

Details of charges

That you, a registered nurse:

1. On 21 December 2017, incorrectly administered Oxycodone to Patient A, when the prescription was for Oramorph;

2. On 19 September 2018, administered a glucose and actrapid infusion to the incorrect patient;

3. On 16 May 2019, administered 20mg of OxyContin to Patient B, when the prescription was for 10mg of OxyContin;

4. Following your conduct at charge 3;

    a. Asked Colleague A to change Patient B's prescription to reflect the incorrect dose that you administered;
    b. When Colleague A refused to change Patient B's prescription, told Colleague A, 'this conversation never happened', or words to that effect;
    c. Stated that the error occurred around midnight in your initial local statement, when it actually occurred around 9pm;

5. Your conduct at charges 4.a. and/or 4.b. was dishonest, in that you were attempting to cover up your conduct at charge 3;

6. Your conduct at charge 4.c. was dishonest, in that you knew the error did not occur at midnight, but intended that anyone reading your initial local statement would believe that it did;

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 Mrs Watson was not in attendance and that the Notice of Hearing letter had been sent to both Mrs Watson's registered email addresses by secure email on 16 June 2022.

The panel considered whether notice of this hearing had been served in accordance with the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ('the Rules'). It noted that under the recent amendments made to the Rules during the Covid-19 emergency period, a Notice of Hearing/Meeting may be sent to a registrant's registered address by recorded delivery and first-class post, or to a suitable email address on the register.

Ms Millar, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

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

In the light of all of the information available, the panel was satisfied that Mrs Watson 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 Mrs Watson

The panel next considered whether it should proceed in the absence of Mrs Watson. It had regard to Rule 21 and heard the submissions of Ms Millar who invited the panel to

continue in the absence of Mrs Watson. She submitted that Mrs Watson had voluntarily absented herself.

Ms Millar referred the panel to an email from Mrs Watson to the NMC dated 17 December 2021 in which she stated:

> *"I don't want to be involved but I'm happy for the case to continue."*

The panel accepted the advice of the legal assessor.

The panel is aware that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Mrs Watson. In reaching this decision, the panel has considered the email from Mrs Watson dated 17 December 2021.

It has also considered the submissions of Ms Millar and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 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 Mrs Watson;
- Mrs Watson has informed the NMC that she is not attending and that the hearing should proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 5 professional witnesses have been warned to give evidence;

- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the patients who need their professional services;
- The charges relate to events that occurred in 2017, 2018 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 Mrs Watson in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her via secured email, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated to some extent. 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 Mrs Watson's decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Background

On 27 September 2019, the NMC received a referral from the Deputy Director of Nursing at the Calderdale & Huddersfield NHS Foundation Trust (the Trust) in relation to concerns about Mrs Watson's practice. At this time, Mrs Watson was employed by the Trust as a Band 5 Staff Nurse, within Ward 8A ('the Ward') at Calderdale Royal Hospital in Halifax. The Trust raised concerns about Mrs Watson's probity and medicines administration following the alleged events of 16 May 2019. On this date, Mrs Watson had administered

20mg of OxyContin to a patient, instead of the 10mg that was prescribed. She had then allegedly tried to conceal the medication error by asking the on-call Advanced Clinical Practitioner ('ACP') to change the patient's prescription to reflect what she had administered. The ACP raised concerns and this led to a Trust investigation.

Mrs Watson had engaged with this local investigation. It is further alleged that Mrs Watson was dishonest in her initial statement to the Ward Manager, stating that the error happened much later in the evening, and failing to mention that she had asked her colleague to change the prescription.

Mrs Watson was dismissed by the Trust on 20 September 2019.

The Trust also raised two previous medication administration errors, occurring on 21 December 2017 on the Ward and 19 September 2018 on Ward 21 at Huddersfield Royal Infirmary.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Millar on behalf of the NMC and the accounts by Mrs Watson in her local statements.

The panel has drawn no adverse inference from the non-attendance of Mrs Watson.

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:

- Ms 1: Matron for the Surgical and Anaesthetic Division at the Trust;
- Ms 2: Manager of the Elective Orthopaedic ward and Mrs Watson's line manager at the time of the incidents at the Trust;
- Ms 3: Matron for Critical Care;
- Mr 4: Advanced Clinical Practitioner at the Trust;
- Ms 5: Staff Nurse at the Trust.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor which included reference to the cases of *Wingate and Evans V SRA* and *SRA v Malins [2018] EWCA Civ 366* and *Ivey v Genting Casinos (UK) Ltd trading as Crockfords [2017] UKSC 67.*

It considered the witness and documentary evidence provided by the NMC.

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

Charge 1

1. On 21 December 2017, incorrectly administered Oxycodone to Patient A, when the prescription was for Oramorph

This charge is found proved.

In reaching this decision, the panel took into account Mrs Watson's local statement to the Trust and the evidence of Ms 1, Ms 2, the Datix report and the patient's notes.

The panel first considered Mrs Watson's local statement to the Trust written the day after the incident, in which she stated the following:

> *"…of course if id correctly scanned it would of informed me it was the wrong patient… it was brought to light id given the patient oxycontin for pain when he was actually prescribed morphine …*[sic]*"*

The panel considered Ms 1's witness statement dated 25 June 2021 in which she wrote:

> *"On 21 December 2017 the registrant administered Oxycodone to a patient instead of the Oramorph that was prescribed.*
> *…*
>
> *The trust has a computerised system for the medication charts. The registrant had opened the wrong medication chart. She'd dispensed some Oxycodone from the CD cupboard and given it to t* [sic] *patient A, when it was patient B's medication chart on the computer.*
> *…*
>
> *There was a risk of harm to the patient, if he'd been allergic to the medication. There was a further risk because the registrant was looking at the wrong drug chart, the patient may have already received opiate medication. The system wouldn't have alerted the registrant to the error as she was looking in the wrong record…"*

The panel next considered Ms 2's witness statement dated 20 October 2021 in which she said:

"On 21 December 2017 the registrant was involved in a medication error where she administered OxyNorm to a patient instead of the Oramorph that was prescribed..".

The panel noted the 'Nursing Handover Note' in the patient's notes in which it records the following:

"Addendum by [staff member] on 21 December 2017 14:07 GMT (Verified) given oxycod0odne liquid instead of oramorph bymember of staff, datix completed and acp awae , error documented on drug chart" [sic]

The panel then had sight of the Datix report in which it was confirmed that the above error as charged had been documented.

The panel noted that as a result of the above error, Mrs Watson was required to do a Medicine Preparation and Administration Performance Review which was carried out by another sister between 2 May 2018 and 29 September 2018 and included three supervised drug rounds and a written reflection by Mrs Watson including the following:

"*…on reflection it has totally changed my practice, I can provide evidence that my scanning has improved month by month achieving 98% in April, my ESR learning is 100% and I no longer can be side tracked, I must give medicine management my full attention… Although I wish this incident had never happened, on reflection I believe it has improved my day to day practice."*

The panel received evidence that Oxycodone and Oramorph were different from each other and were used for different purposes. The panel therefore had clear evidence to demonstrate that Mrs Watson had misidentified the patient and administered the incorrect medication to the patient. However, the panel bore in mind that no patient harm occurred.

The panel concluded that the above evidence clearly supports this charge. On this basis, the panel concluded that on 21 December 2017, Mrs Watson incorrectly administered Oxycodone to Patient A, when the prescription was for Oramorph.

The panel therefore found charge 1 proved.

Charge 2

> 2. On 19 September 2018, administered a glucose and actrapid infusion to the incorrect patient

This charge is found proved.

In reaching this decision, the panel took into account the handwritten statement from Mrs Watson dated 22 September 2018, the local statement of Ms 6, Ms 1's evidence, Ms 2's evidence and the Datix report.

The panel noted that Mrs Watson in her handwritten statement dated 22 September 2018 stated:

> *"There really is no excuse other than upset state I was in (sic)*
>
> *The pump was attached to the wrong patient."*

The panel further noted that Ms 6, the Health Care Assistant (HCA) with whom Mrs Watson was working at the time of the incident, said in her local statement that she had noticed that the infusion had been attached to the wrong patient and therefore with the help of colleagues was able to stop the infusion before it had finished. She said in her local statement:

"Whilst in the room noticed the syringe from the infusion had a different name to the patient asked [ ] to go get the nurse in charge immediately. Staff nurse [ ] came round and stopped the infusion immediately."

The panel also had sight of Ms 1's witness statement dated 16 April 2021, in which she said:

"On the night shift of 19 September 2018 the registrant administered a glucose and actrapid infusion to the wrong patient.

…

The risk of administering glucose and actrapid infusion to a patient who it wasn't prescribed for potentially would have lowered potassium levels too much. There are lots of different scenarios, but if the potassium levels are to low or to high it ultimately can lead to cardiac arrest in the worst case scenario [sic]*"*

The panel also bore in mind Ms 1's oral evidence in which she said that Mrs Watson admitted the error and was apologetic. Ms 1 told the panel that Mrs Watson had been upset and flustered as she had been seconded to this ward (in Huddersfield) from a different hospital (in Halifax). Further she had been stressed because she had been delayed by the shuttle bus, the handover had been rushed and the nurse performing the handover had been difficult to understand, and some of the patients had not been wearing wrist bands or were wearing wrist bands which could not be scanned.

The panel further bore in mind Ms 1's evidence that a second checker had not been present when the medication was administered.

The panel had regard to the patient's notes for this incident and the Datix report in which the above error as charged had been documented.

The panel noted that the Medicine Preparation and Administration Performance Review related to the first error (Charge 1) was not completed and signed off until 29 September

2018. Mrs Watson had nevertheless made the second error (Charge 2) on 19 September 2018, before that Review had been completed. This second error again involved misidentification of a patient.

The panel also noted that after this second incident, Mrs Watson was again subject to a medication competency review, this time by Ms 2. It noted that Ms 2 stated in her witness statement dated 20 October 2021 that:

> *"I did 5 supervised drug rounds with the registrant from 15 December 2018 onwards, the registrant could tell me what the drugs were for, the correct process of giving out drugs eg: scan patient's wristbands, and check their names. She could do all that perfectly, it was decided that she was safe to continue."*

The panel concluded that the above evidence, including Mrs Watson's acceptance of this drug error in her local statement, clearly supports this charge. On this basis, the panel concluded that on 19 September 2018, Mrs Watson administered a glucose and actrapid infusion to the incorrect patient.

The panel therefore found charge 2 proved.

Charge 3

> 3. On 16 May 2019, administered 20mg of OxyContin to Patient B, when the prescription was for 10mg of OxyContin

This charge is found proved.

In reaching this decision, the panel took into account Mrs Watson's local statement dated 26 July 2019, Mrs Watson's undated handwritten statement, and the evidence of Ms 2, Ms 3, Mr 4 and Ms 5.

The panel had sight of Mrs Watson's local statement dated 26 July 2019 in which she said:

> *"When I came out of the cubicle, I signed the register and put that I had given 2 tablets (20mg instead of 10mg). It was then that I realised what I had done. I said "oh my god, oh my god, oh my god". I lost it for want of a better word. We were both were in bits(sic)."*

The panel also noted that Mrs Watson wrote in her handwritten statement that:

> *"…in a complete lack of concentration I said its 20 mg and took them to the patient, I explained they were long acting but if she had any pain or discomfort she should let one of us know. We signed the book and register and came out of the cubicle, I don't know if it was returning the book and meds into the cupboard or it was an instant thought, "she was a 23 hr knee and we have given her 20 mg" (I knew this was the protocol for 24 hrs (sic) knee) I was totally devastated immediately, I was in tears so I went into the office, I was so upset as I knew the implication this would have on me professionally and personally."*

The panel had sight of Ms 2's witness statement dated 20 October 2021 in which she wrote:

> *"I found out about the medication error when [Mr 4] called me at 21:50 that night. He informed me that there had been a drug error, that the nurse had given too much Oxycodone and that he'd been asked to change the prescription."*

The panel also noted that Mr 4 in his local statement dated 25 July 2019 stated:

> *"She explained to me that she had made a drug error and had administered 20mg of Oxycontin to a patient who was only prescribed 10mg. She asked me to change*

the prescription to conceal this error. I was shocked and explained that I would need to review the patient immediately and consider her request."

Further, the panel also noted the contents of Mr 4's witness statement dated 13 April 2021 in which he said:

"The registrant said that she had made an error. The registrant then explained that she had given a patient too much Oxycodone modified-release and asked if I (sic) change the prescription to reflect this

…

Initially I was concerned as she had administered double the dose you would usually give a patient. I was worried as the patient was of a slight build. I went to review the patient. The patient was awake and alert and did not appear to be in any pain or distress suggesting the need for additional analgesia.

…

While this incident resulted in no harm to the patient, there was a potential risk of harm. The risks of overdose of oxycodone include but are not limited to; potentially a risk of death (which is common with all opiates if given in significant doses),hypotension, nausea, muscle rigidity, bradycardia, palpitations, confusion, loss of consciousness, respiratory depression and sedation."

The panel also bore in mind Ms 3's witness statement dated 13 April 2019 in which she stated:

"The error which occurred was that a patient was prescribed 10mg of Oxycodone, but the nurse's actually gave 20mg. The registrant's rationale for the error was that sometimes the prescription says 10 -20mg at the nurses discretion. This prescription was not for the nurses' discretion and specifically prescribed 10mg"

The panel then in its consideration of this charge, had sight of Ms 5's written statement dated 12 December 2020 in which she wrote:

"The registrant said to me the patient is on 20 mg Oxycodone modified release. I then popped two tablets, two times 10mg of oxycodone modified release into a little pot and I gave it to the registrant. I didn't check the prescription."

The panel understood from the evidence it had heard from Mr 4 that both himself and Mrs Watson had completed Datix reports. However, the panel was not provided with these documents. Further, the panel was told by Ms 2, Ms 3 and Ms 5 that both Ms 5 and Mrs Watson had completed local statements on the day, whilst they were completing the Datix reports. These too were not provided to the panel. The panel bore in mind Ms 1's evidence in which she said that she had handed the initial statements to Ms 2, however it was Ms 2's position that they had been kept by Ms 1.

The panel was of the view that, notwithstanding the lack of the above initial statements and Datix reports, it had more than sufficient evidence before it to satisfy it regarding this charge. The panel concluded that the evidence available to it, including Mrs Watson's own local statements accepting this drug error, clearly supports this charge. On this basis, the panel concluded that on 16 May 2019, Mrs Watson administered 20mg of OxyContin to Patient B, when the prescription was for 10mg of OxyContin.

The panel therefore found charge 3 proved.

Charge 4a

4. Following your conduct at charge 3;

    a. Asked Colleague A to change Patient B's prescription to reflect the incorrect dose that you administered

This charge is found proved.

In reaching this decision, the panel took into account Mrs Watson's local statement dated 26 July 2019, the evidence of Ms 2, Ms 3, Mr 4, Ms 5 and Mr 4's local statement.

The panel first had sight of Mrs Watson's local statement dated 26 July 2019 in which she stated:

> *"I am so sorry for asking [Mr 4] and putting him in this position. I am beyond heartbroken professionally and personally at this moment in time that [Ms 5] felt that she had to do it for me when it was us, a two person thing..."*

Mr 4 said in his oral evidence said that Mrs Watson had asked him to change the prescription at least 3 times. The panel recalled that Mr 4 said "*she was deadly serious in asking me to change the prescription*" and that he felt pressured and that she had told him that "*if she lost her job because of this it would be his fault."*

The panel had sight of Mr 4's statement dated 19 January 2021 in which he wrote:

> *"I can't remember the exact wording but I said to her that if I were to change the patient's prescription we would be missing some drugs. The registrant suggested that she would give another patient (I'm not sure who) a short/ reduced dose to balance the register. It's not the fact that the registrant had made an error that was my main concern; it was the level of deceit to conceal the error that was being considered."*

The panel found Mr 4 to be a reliable and truthful witness. The panel was of the view that Mr 4 was consistent both in his oral and written evidence. The panel also bore in mind his evidence in which he said that he had made contemporaneous notes in his reflective journal in order to ensure the details of the incident were accurately recorded, and further, that he had telephoned Ms 2 within an hour of the incident to inform her of what had happened. Ms 2 corroborated this evidence during her oral evidence. When questioned as

to how sure she was that Mr 4 had told her that Mrs Watson had asked him to change the prescription, Ms 2 said she was *"100% sure".* Further when she was asked whether she had asked Mrs Watson about this, she said *"yes yes".* She went onto say that Mrs Watson had replied that '*It didn't happen so what's the problem'*. Ms 3 corroborated this in oral evidence, telling the panel that Mrs Watson *"…didn't think it was an issue that she'd asked someone to change a prescription. She said "he didn't, so what's the issue?"* The panel infers from this remark that Mrs Watson agreed (implicitly) that she had asked Mr 4 to change the prescription but felt that as he had refused to do so, no harm had been done.

The panel bore in mind Ms 3's oral evidence in which she said that she was *"shocked due to the level of deceit she [Mrs Watson] was prepared to go to hide the error."*

Finally, in considering this charge, the panel bore in mind Ms 5's evidence. It was of the view that she appeared guarded in her evidence and the panel considered that this may have been because she was also implicated in the incident. The panel noted that Ms 5 did not recall Mrs Watson asking Mr 4 to change the prescription. However, the panel noted that Ms 5 wrote in her witness statement dated 16 December 2020 that:

> *"I don't remember the registrant specifically asking [Mr 4] to change the prescription. It was more the registrant thinking out loud of ways around the error. The registrant was still panicking. She asked [Mr 4] "could you prescribe her another 10 mg". She was trying to cover the error up."*
>
> *"She was coming up with ideas, like, if the patient vomited the Oxycodone, she would need another dose of 10mg, which would be equivalent to the 20mg we had given her."*

The panel took into account all the evidence above. It concluded that the evidence clearly supports this charge. On this basis, the panel concluded that following Mrs Watson's conduct at charge 3 above, she asked Colleague A (Mr 4) to change Patient B's prescription to reflect the incorrect dose that she administered.

The panel therefore found charge 4a proved.

Charge 4b

4. Following your conduct at charge 3;

    b. When Colleague A refused to change Patient B's prescription, told Colleague A, 'this conversation never happened', or words to that effect

This charge is found proved.

In reaching this decision, the panel took into account Mrs Watson's handwritten statement, Mrs Watson's local statement dated 26 July 2019 and the evidence of Ms 3.

The panel first had sight of Mrs Watson's handwritten statement in which she wrote:

> *"I said I was sorry for asking him and the conversation had never happened."*

The panel then considered Mrs Watson's local statement dated 26 July 2019 in which stated she told Mr 4 that:

> *"I am really sorry for putting you in a compromising position and as far as I am concerned this conversation has not happened."*

The panel also had sight of Ms 3's statement dated 13 April 2021 in which she wrote:

> *"At the formal interview she said that she felt bad that she put [Mr 4] in that position asking him to make the change. She also said that when [Mr 4] said he wouldn't change the prescription she said to him 'well then this conversation never happened'.*

The panel concluded that the above evidence was sufficiently clear to support this charge. On this basis, the panel concluded that, following Mrs Watson's conduct at charge 3, when Colleague A (Mr 4) refused to change Patient B's prescription, she told Colleague A "this conversation never happened', or words to that effect.

The panel therefore found charge 4b proved

Charge 4c

4. Following your conduct at charge 3;

    c. Stated that the error occurred around midnight in your initial local statement, when it actually occurred around 9pm

This charge is found proved.

In reaching this decision, the panel took into account Mrs Watson's handwritten statement and the evidence of Ms 5, Ms 2, and Mr 4.

The panel noted that Mrs Watson had stated in her local handwritten statement:

> *"I was in such a state that I went outside for a cigarette and returned so I know this was before 9.30 as the front doors lock then."*

The panel then had sight of Ms 5's witness statement dated 16 December 2020 in which she wrote:

> *"We completed the datix together. When we were filling out the datix we did discuss what we would say if they ask why we reported the incident three hours after it happened. The registrant suggested we say that because the patient was a day*

case we were just looking at her chart and that's how we came upon the error, which is not true. According to the NMC code an error should be reported in a timely manner. This isn't always possible on ward as things happen, things can get busy and there is lots of work to do. What we didn't realise was that datixs can be retrospective, you can back date it.

…

The registrant's state of mind that shift was sheer panic. She was scared of losing her job and getting struck off. She was thinking of the worst case scenario that could happen to her or her career. She wasn't thinking straight.

…

The error occurred at 20:50 and we didn't report it till midnight because of all the stuff that was happening. We had a few post op patients that evening and ward work that didn't allow us to do it much earlier."

The panel then noted that Mr 4 said in his witness statement dated 19 January 2021:

"Early in the shift at approximately 20:30 I received a bleep message asking me to telephone Ward 8. The way the Bleep system works is that a bleep goes off and it displays a phone number. I recognised the phone number as Ward 8. As my office is situated just outside the ward I attended the ward, rather than telephoning and the Registrant met me. Her exact words to me were "I need a favour".

The registrant asked me to come have a word with her in the office. Such a request isn't uncommon. Quite often because we are experienced clinicians, staff ask for favours but this is usually personal medical advice or a request for teaching or a reference.

The registrant said that she had made an error. The registrant then explained that she had given a patient too much Oxycodone modified-release and asked if I change the prescription to reflect this."

The panel also had regard to Ms 2's witness statement dated 20 October 2021 where she stated:

> *"I found out about the medication error when [Mr 4] called me at 21:50 that night. He informed me that there had been a drug error that the nurse had given too much Oxycodone and that he's been asked to change the prescription. I asked him, how the patient was. I also asked who asked him, was it the registrant or [Ms 5] or both of them that asked him to change the prescription. He said that it was the registrant and that he hadn't [changed] the prescription…[*sic]*"*

The panel further reminded itself that Ms 2 said in her oral evidence that both Mrs Watson and Ms 5 had initially said the error happened at midnight and that *"they said they had a moment of realisation at midnight…"*

Having found both Ms 2 and Mr 4 to be credible and reliable witnesses and further backed up by Ms 5's evidence that the incident occurred around 9pm, the panel was of the view that the above evidence was sufficiently clear to support this charge despite the fact that the panel was not provided with the initial local statements. On this basis, the panel concluded that, following Mrs Watson's conduct at charge 3, Mrs Watson stated that the error occurred around midnight in her initial local statement, when it actually occurred around 9pm.

The panel therefore found charge 4c proved

Charge 5

> 5. Your conduct at charges 4.a. and/or 4.b. was dishonest, in that you were attempting to cover up your conduct at charge 3;

This charge is found proved.

In reaching this decision, the panel took account of its decisions at charges 4a and 4b above, Mrs Watson's local statement dated 26 July 2019 and her handwritten statement and the evidence of Ms 2, Ms 3 and Mr 4.

The panel had regard to Mrs Watson's local statement dated 26 July 2019 in which she stated:

> *"I am so sorry for asking [Mr 4] and putting him in this position. I am beyond heartbroken professionally and personally at this moment in time that [ ] felt that she had to do it for me when it was us, a two person thing. I did not verbally get her to do something but how upset I was has been interpreted into pressuring her to cover up the error. I do not feel that I positively put her in that position and it was her response to my upset. I cannot stand that people now think that I am dishonest. I am aware that it should not have come out of my mouth but the result of that knee jerk reaction has resulted in people thinking that I am dishonest."*

The panel also bore in mind Mrs Watson's handwritten statement in which she stated:

"I was totally devastated immediately, I was in tears so I went to the office, I was so upset as I knew the implication this would have on me professionally and personally.

The panel reminded itself that Mr 4 said in his witness statement dated 19 January 2021:

> ***"****Early in the shift at approximately 20:30 I received a bleep message asking me to telephone Ward 8. The way the Bleep system works is that a bleep goes off and it displays a phone number. I recognised the phone number as Ward 8. As my office is situated just outside the ward I attended the ward, rather than telephoning and the Registrant met me. Her exact words to me were "I need a favour".*
>
> *The registrant asked me to come have a word with her in the office. Such a request isn't uncommon. Quite often because we are experienced clinicians, staff ask for*

favours but this is usually personal medical advice or a request for teaching or a reference.

The registrant said that she had made an error. The registrant then explained that she had given a patient too much Oxycodone modified-release and asked if I change the prescription to reflect this.

"It's not the fact that the registrant had made an error that was my main concern. It was the level of deceit to conceal the error that was being considered.

The panel then considered Ms 5's witness statement dated 16 December 2020 where she said the following:

"…After about five to ten minutes of panic, the registrant bleeped [Mr 4] ACP and asked him to come to the ward. At around 21:10 [Mr 4] came onto the ward. At the nurse's station, [Mr 4], the registrant and I had a conversation. The registrant explained what had happened. She was coming up with ideas, like, if the patient vomited the Oxycodone, she would need another dose of 10mg, which would be equivalent to the 20 which we had given her. At handover that night we had been told that the patient had been vomiting in the day.

The registrant also suggested taking tablets from the ward stock and putting them into the patient's stock. I told her that this wouldn't work as then the wards stock would be down some tablets. I also told her it was wrong and that covering up the error would make everything worse. [Mr 4] was saying that this patient was a day case knee patient and they did regular audits on them.

I don't remember the registrant specifically asking [Mr 4] to change the prescription. It was more the registrant thinking out loud of ways around the error. The registrant was still panicking. She asked [Mr 4] "could you prescribe her another 10 mg". She was trying to cover the error up…"

The panel appreciated that Mrs Watson would have been in state of panic following the incident and may not, at that time, have been thinking straight. However, the panel was of the view that by the time she decided to bleep Mr 4 and ask for his help, Mrs Watson had formed the intention to conceal her error. During that conversation she suggested several ways to cover up the mistake. In the panel's view this was not a "*knee jerk reaction*" but on the contrary, demonstrated deliberate planning and calculated thinking. The panel does not doubt that Mrs Watson panicked, but she was nevertheless able to concoct and articulate several dishonest strategies to cover up her error. According to Mr 4 she made "*at least three*" requests for him to change the prescription, before she was eventually persuaded by Ms 5 to report the incident around midnight. The dishonesty was not, therefore, momentary, but was sustained over a period of several hours. In the panel's view that is not consistent with a "*knee jerk reaction*".

In the panel's view, when Mrs Watson was experiencing a panicked reaction as she realised her error, the appropriate and usual response for a nurse would be to seek support immediately from the matron on duty.

The panel was also concerned to note Mrs Watson's clear intention to involve others (Mr 4, an ACP, and Ms 5 a newly qualified nurse) in her attempts to conceal the error, asking Ms 5 "*do you think [Ms 4] will help us?"*

The panel had regard to Ms 2 witness statement dated 20 October 2021 in which she wrote:

> *"I don't think the registrant showed any insight into the error. I think she was dishonest, the fact that when I next spoke to her about the error and asked for their statement. The timing that both the registrant and [Ms 5] gave for the time of the error was dishonest. They stated that the error occurred at midnight when it occurred at least 3 hours earlier. She knew she was in trouble, it was "how can I get out of it?" If she could have been honest It couldn't have come to this…"*

Having found charges 4a and 4b proved, the panel has already concluded that there is clear evidence that Mrs Watson asked Colleague A (Mr 4) to change Patient B's prescription to reflect the incorrect dose that she administered and, when Colleague A (Mr 4) refused to change Patient B's prescription, told Colleague A, 'this conversation never happened', or words to that effect. The panel further determined that there is sufficient information before it to conclude that Mrs Watson's priority was the implications of her errors on herself *"both personally and professionally"* rather than the safety of the patient. The panel was of the view that Mrs Watson's action in asking a colleague to cover up the error was motivated by self-preservation, to prevent adverse consequences for her career. Further, when Mr 4 refused to commit such an action, to state that *"this conversation never happened"* demonstrates an intention to cover up the first dishonest request. 'The panel determined that through Mrs Watson's actions, she put both Ms 5 and Mr 4 in a very difficult position whilst she dishonestly cast around for ways in which to cover up her medication error.

The panel determined that there was clear evidence before it to conclude that Mrs Watson's conduct at charges 4a and 4b was dishonest, in that she was deliberately attempting to cover up her conduct at charge 3.

The panel therefore found charge 5 proved in relation to both charge 4a and 4b.

Charge 6

6. Your conduct at charge 4.c. was dishonest, in that you knew the error did not occur at midnight, but intended that anyone reading your initial local statement would believe that it did

This charge is found proved.

In reaching this decision, the panel took into account its decision at charge 4c above and the evidence of Ms 2, Ms 3 and Ms 5.

The panel had regard again to Ms 2 witness statement dated 20 October 2021 in which she wrote:

> *"I don't think the registrant showed any insight into the error. I think she was dishonest, the fact that when I next spoke to her about the error and asked for their statement. The timing that both the registrant and [Ms 5] gave for the time of the error was dishonest. They stated that the error occurred at midnight when it occurred at least 3 hours earlier. She knew she was in trouble, it was "how can I get out of it?" If she could have been honest It couldn't have come to this…"*

The panel also reminded itself that in her oral evidence, Ms 2 said that she took an initial statement from Mrs Watson who had said that the incident had taken place at midnight. Ms 2 told the panel that she had known that not to be true and therefore had put that account to Mrs Watson whose response had been *"I'm in trouble".*

The panel then considered the written statement of Ms 3 dated 13 April 2021 who stated:

> *"There was a lot of doubt about what the registrant had written in her statement. The initial statement she had written was untrue. She admitted this at this meeting. She admitted that the timing wasn't correct. She gave a rationale for why she wrote the wrong timing. She said that as the time they informed the night matron, was so long after the error occurred, they thought they had to say the incident occurred at a later time. They thought they had to say that they realised the error occurred at the same time as they had documented in the datix. In the statement they said they had a revelation at midnight something to do with the patient being a 23 hr knee."*

The panel also had regard to Ms 5's witness statement dated 16 December 2020 in which she wrote:

"We completed the datix together. When we were filling out the datix we did discuss what we would say if they ask why we reported the incident three hours after it happened. The registrant suggested we say that because the patient was a day case we were just looking at her chart and that's how we came upon the error, which is not true. According to the NMC code an error should be reported in a timely manner. This isn't always possible on ward as things happen, things can get busy and there is lots of work to do. What we didn't realise was that datixs can be retrospective, you can back date it…"

The panel further reminded itself that Ms 2 said in her oral evidence that both Mrs Watson and Ms 5 had initially said it happened at midnight and that *"they had a moment of realisation at midnight…"* The panel bore in mind that Ms 5 had to persuade Mrs Watson to report the incident and that Mrs Watson had suggested to Ms 5 that they should change the time from around 9pm to midnight. The panel noted that Ms 3 had stated in oral evidence that she found it difficult to believe that Mrs Watson had said to her that she did not know that a Datix could be completed retrospectively, as her two previous errors had been recorded on Datix. In her view Mrs Watson would have been very well aware that a Datix could be completed after the event and would know that the reporter should record the time the incident had occurred. In the panel's view, as an experienced nurse who had had two previous incidents reported on Datix, Mrs Watson would have known that the Datix should reflect the correct time of the incident. It concluded that Mrs Watson had deliberately tried to create the impression that the incident had occurred later than it did, in order to conceal the delay in reporting it.

The panel was of the view that the above evidence was sufficiently clear to support this charge. On this basis, the panel concluded that, Mrs Watson's conduct at charge 4c was dishonest in that she knew the error did not occur at midnight but intended that anyone reading her statement would believe that it did.

The panel therefore found charge 6 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 Mrs Watson'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, Mrs Watson's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Ms Millar invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Ms Millar identified the specific standards where she submitted that Mrs Watson's actions amounted to misconduct. She submitted that the charges relating to dishonesty are particularly serious. She submitted that, despite support being in place in the form of medication competency assessments, Mrs Watson continued to make medication errors.

Ms Millar also submitted that Mrs Watson's errors exposed patients to the risk of harm. She reminded the panel that, although there was no evidence of actual harm caused, Mrs Watson's three medication errors had all put the patients at risk of serious harm. In particular, she submitted that Mrs Watson exposed the patient in charge 3 to risk by stating in her statement that the error occurred at midnight when it had occurred at about 9pm and by doing so, she had set out to conceal her errors. Ms Millar told the panel that instead of reporting the error and trying to address the mistake by reviewing the patient, she had spent her time thinking of ways to cover up the incident. Mrs Watson had therefore put her own interests above those of the patient and she was not transparent about her error.

Ms Millar also submitted that the panel's findings at the fact stage included Mrs Watson attempting to involve her colleagues in the covering up of her medication error in Charge 3. Ms Millar submitted that by doing so Mrs Watson put both Mr 4 and Ms 5 in a difficult position. She further reminded the panel that Mrs Watson was Ms 5's senior and had made Ms 5 feel as though she was put under pressure and had to agree to delay calling the Matron and to change the timing of the error in their Datix report. Further, Ms Millar submitted that Mrs Watson acted in breach of a number of internal Trust policies in respect of all three errors. Ms Millar submitted that Mrs Watson has also been found to be acting dishonestly and submitted that Mrs Watson's actions fell far short of the standards expected of a registered nurse and amounted to misconduct.

Ms Millar moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Millar invited the panel to find that Mrs Watson's fitness to practise is impaired both on the grounds of public protection, and also in the public interest. She submitted that Mrs

Watson has not provided the panel with any information to show that she had attempted to address the concerns. Ms Millar reminded the panel that two of the medication errors had occurred whilst Mrs Watson was being supported by the Trust. She further submitted that, from the witness evidence, it appeared that Mrs Watson had shown minimal insight during the local level investigation regarding the medication errors and had sought to pass blame onto others. Ms Millar submitted that Mrs Watson's dishonesty demonstrated an attitudinal problem.

Ms Millar also submitted that, given the lack of information provided by Mrs Watson, there is no material to suggested that Mrs Watson has shown insight into her actions nor that she has remediated the concerns or addressed the dishonesty. She therefore submitted that there is a risk of repetition, and a risk of harm to the public should Mrs Watson be permitted to practise unrestricted.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments including *General Medical Council v Meadow [2006] EWCA Civ 1390* and *Nandi v GMC [2004] EWHC 2317 (Admin).*

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* The misconduct must however fall significantly short of the standards expected of a registered nurse.

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

The panel determined that Mrs Watson's actions amounted to a number of breaches of the Code. Specifically:

*"**1 Treat people as individuals and uphold their dignity***

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

10 Keep clear and accurate records relevant to your practice

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

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

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

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

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

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

Promote professionalism and trust

The code states:
You must uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

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

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken."

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that Mrs Watson's actions detailed in charges 1- 6 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct. It bore in mind that Mrs Watson had made three separate serious medication errors involving vulnerable patients, within three years, despite support from the Trust. The panel determined that Mrs Watson's failures to scan the patients' bar codes and correlate them with the patients' prescriptions as per Trust policy caused her to misidentify patients. Failing to have a second checker present during the administration of controlled drugs in charges 1 and 3 was a serious breach of local and national guidelines. It considered that Mrs Watson's failure to check prescriptions and identities before administering drugs to a patient was to fail at a basic nursing skill. Mrs Watson did not ensure the second checker was present throughout the medication administration process in respect of all three charges, and in charge 3 had failed to ensure the second checker was giving the process their full attention.

The panel was further of the view that Mrs Watson's decision to ask a junior colleague to assist her in the concealing of an error and making her "*feel pressured*" to not escalate the matter; and similarly asking Mr 4 to change the prescription to conceal her error "*otherwise she may be at risk of losing her job*" were such serious departures from the expected standards of behaviour for a nurse, that it could only be judged to be misconduct. The panel was of the view that in doing so Mrs Watson had abused her position as an experienced and senior staff nurse. It determined that as such an experienced and senior nurse, her misconduct and, in particular, her dishonesty in trying to cover up the third error, would be viewed by the profession as "*deplorable*".

In conclusion, the panel found that Mrs Watson's actions as a whole, both individually and cumulatively, 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, Mrs Watson'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 *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

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

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

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

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

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

The panel determined that all four limbs of the Grant test are engaged in this case both in the past and in the future. The panel bore in mind that Mrs Watson made three sperate medication errors within three years, despite support provided by the Trust during this time, which included two medication competency re-training programmes. It decided that, although patients were not caused actual harm by Mrs Watson's actions, there was potential for very serious harm as a result of her misconduct. The panel reminded itself of the evidence it had heard that the concerns in 2017 and 2019 could have caused the patients to have opiate overdoses which could have resulted in their death. Further, the incident in 2018, could (if it had not been noticed by the HCA in time to stop the infusion) have caused the elderly patient's potassium levels to fall dramatically and as such could have caused a high risk of death from cardiac arrest/ arrythmia. The panel determined that Mrs Watson's misconduct, in particular her dishonesty, breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel noted that there is often a risk to patient safety when a nurse makes a medication error and does not correct it immediately or escalate it. The panel bore in mind that Mrs Watson appeared to be more concerned about the impact of her errors, in particular the third error, on herself than about the safety of her patient: *"I was so upset as I knew the implication this would have on me professionally and personally".* In the panel's view the evidence about whether and, if so when, Mrs Watson had reviewed this patient herself was inconclusive. It had seen no evidence that Mrs Watson had done so, but that may have been because Mr 4 had done this after Mrs Watson called him. The panel noted that it had seen no evidence of insight or evidence of any steps taken to strengthen her practice since the last incident, or to address her dishonest actions. Whilst the panel noted that Mrs Watson had made some apologies for her actions in her local level statements, they did not address all the relevant concerns, particularly her attempts to cover up her error. The panel considered that her insight into the impact her actions had on her patients, colleagues, and the wider nursing profession is yet to be addressed. Further, there is nothing before this panel by way of recent apologies or remorse and no evidence of any insight into the harm which could have been caused to patients or the reputation of the profession.

The panel was concerned by the evidence it had heard from Ms 2 that Mrs Watson is described as "*someone who was constantly making mistakes and not learning from them"* and that *"she never acknowledged any fault".* Further it bore in mind Ms 3's evidence in which she said "*I don't think she realised the impact on them of asking Mr 4 to change the prescription and Ms 5 to keep quiet.*" It also reminded itself that Ms 3 had noted Mrs Watson's lack of concern for her errors and her lack of insight into the seriousness of her conduct in asking her colleagues to help her cover up the error. The panel noted that Ms 3 had reported her concerns in this regard to the Deputy Director of Nursing at the Trust.

The panel also noted that Mrs Watson has not provided any reflection and has not addressed the concerns, or outlined what she would have done differently or recognised the impact of her actions.

Taking all these factors into account, including the fact that the medication errors had occurred on three separate occasions, two of them whilst being supported, and the lack of insight into her dishonesty, the panel determined that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding proper professional standards for members of those professions.

The panel determined that, in this case, a finding of impairment on public interest grounds was also required. The panel considered that the public would expect a registered nurse to act with integrity and honesty, and would expect the regulator to take action in cases where a nurse has been found to be dishonest in relation to medication errors involving vulnerable patients. Further it would also expect the regulator to take action when a nurse had been found attempting to persuade two colleagues to assist her in concealing such errors. The panel considered that proper professional standards and public confidence in the profession would be undermined if a finding of current impairment were not made. Therefore, the panel also finds Mrs Watson's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Watson'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 Mrs Watson's name off the register. The effect of this order is that the NMC register will show that Mrs Watson 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 Millar informed the panel that, whilst recognising that the decision on sanction was for the panel alone, the NMC is seeking the imposition of a suspension order for a period of nine months as the appropriate sanction in this case.

She took the panel through the aggravating and mitigating features of Mrs Watson's case and referred the panel to the sanctions available and, for each, set out the view of the NMC. She stated that the panel should consider the NMC guidance on 'determining serious cases' in its decision making. She submitted that Mrs Watson's case involved serious breaches, which included multiple medication errors and multiple incidents of dishonesty which is inherently serious. She submitted that Mrs Watson has shown greater concern for herself and her reputation rather than for her patients. Ms Millar submitted that although this case can be considered to be a borderline strike off case, the NMC notes that Mrs Watson's dishonesty was impulsive and not calculated in advance of the error in charge 3. She therefore submitted that a suspension order for a period of nine months would give Ms Watson time to engage, demonstrate insight and show that there is low risk of repetition of her misconduct. Ms Millar submitted that given the seriousness of the concerns identified and the need to have regard to the public interest, the appropriate outcome is a suspension order to uphold trust and confidence in the nursing profession and the NMC as a regulator. However, she submitted that as many of the factors in the guidance for serious cases were present, a striking-off order may be appropriate. It was a matter for the panel's judgement.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Multiple and repeated medication errors even after local support and intervention, from which Mrs Watson appeared not to have learnt;
- Multiple examples of dishonesty and attempts to cover up her third error;
- Attempts to involve others in covering up her third error;
- Demonstrating more concern for her own career than for her patients; and
- Lack of insight into her failings, in particular dishonestly attempting to cover up the third error.

The panel bore in mind Ms Millar's submissions regarding the mitigating features in this case; in particular that that there were some admissions of the errors at local level, and that there were some contextual factors for the first two errors. In the panel's view, the admissions do not amount to significant mitigation as honesty and candour in admitting mistakes is a basic requirement for any registered nurse. However, the panel took account of the contextual factors for the first two errors: lack of experience with the wrist band scanning process (Charge 1) and being busy and stressed on a ward which was not her usual place of work (Charge 2).

However, the panel did not give significant weight to either of these two factors in the circumstances of this case, as these should not have prevented safe practice, and context does not mitigate dishonesty.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection and public interest issues identified, an order that does not restrict Mrs Watson'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 Mrs Watson's misconduct and dishonesty 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 Mrs Watson's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be relevant, proportionate, measurable and workable. It is of the view that the dishonesty found proved represents a serious attitudinal flaw. The dishonesty, taken together with the seriousness of the medication errors, and Mrs Watson's lack of engagement and insight, leads the panel to conclude that the risk of repetition is high and that there are no practical or workable conditions that could be formulated to address the dishonesty in particular. The panel was of the view that although concerns relating to the medication errors might potentially be addressed through re-training, Mrs Watson had already been subject to two competency assessments and continued guidance, but had continued to make errors. Furthermore, the panel concluded that there is no information before it as to whether Mrs Watson is currently working as a nurse and whether she is willing to comply with any conditions, given her lack of engagement. The panel therefore concluded that the placing of conditions on Mrs Watson's registration would not adequately address the seriousness of this case and would not protect the public and public interest concerns.

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 has insight and does not pose a significant risk of repeating behaviour;*
- *…*

The panel was of the view that none of the above factors are apparent in this case.

The panel also had regard to the NMC guidance on *'Considering sanctions for serious cases'* (SAN-2), having particular regard to the guidance relating to cases involving dishonesty in which the following is stated:

> *"The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care.*
>
> *…*
>
> *Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*

- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to patients*
- *premeditated, systematic or longstanding deception…"*

This case concerns medication errors and a dishonest attempt to conceal the final error. The panel noted that although there was no personal financial gain to Mrs Watson, there was a potential personal gain in the form of protecting her career. The panel also found that although Mrs Watson's dishonesty did not appear to be premeditated, systematic or longstanding dishonesty, in that it occurred during one shift, the dishonesty was nevertheless sustained and continued until Mrs Watson was confronted by Ms 2. Additionally, Mrs Watson attempted to involve two members of staff in her dishonesty, one of whom was a junior colleague. The panel was of the view that the risks associated with Mrs Watson's medication errors and her dishonesty are interrelated. The misconduct found proved involved the potential for direct risk of harm to patients. Given her lack of insight into these failings, the risk of repetition of both the medication errors and the likelihood of dishonesty to cover such errors if they were to ever be repeated is also high. The risk of a further medication error carries the risk of a further attempt to cover it up.

The panel noted that the NMC's sanctions bid was for a suspension order for a period of nine months. However, it considered that in light of the repeated medication errors and the repeated dishonesty, it was unlikely that any material presented to a reviewing panel would assist it, even if Mrs Watson did choose to engage with this process. Having determined that it is likely that Mrs Watson's behaviour would be repeated, the panel finds that Mrs Watson poses a real risk to colleagues and the public including vulnerable patients or service users.

The conduct, as highlighted by the charges 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 Mrs Watson's actions is fundamentally incompatible with her remaining on the register.

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

Finally, in relation to a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that the findings in this particular case demonstrate that Mrs Watson's actions are fundamentally incompatible with continued registration and were so serious that to allow her to continue practising as a registered nurse would undermine public confidence in the profession and in the NMC as a regulatory body.

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

The panel considered that this order was necessary to maintain 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 is in Mrs Watson's own interest until the striking-off sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Ms Millar. In light of the panel's decision that Mrs Watson should be struck-off the register, she submitted that an interim suspension order for a period of 18 months should be imposed in order to cover any potential appeal period. She submitted that this was both necessary for the protection of the public and is 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, and the fact that it has imposed a striking-off order preventing Mrs Watson from practising. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential appeal period.

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

That concludes this determination.

This decision will be confirmed to Mrs Watson in writing.