Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday, 4 December – Tuesday, 10 December 2024

Virtual Meeting

Name of Registrant:	**Lauren Brown**
NMC PIN	17B1932E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 15 September 2017
Relevant Location:	Slough
Type of case:	Misconduct
Panel members:	Penelope Titterington (Chair, Lay Member) Sara Morgan (Registrant Member) Kiran Bali (Lay Member)
Legal Assessor:	Hala Helmi (4-9 December 2024) Paul Housego (10 December 2024)
Hearings Coordinator:	Angela Nkansa-Dwamena
Facts proved:	Charge 1 (with respect to Patient 1, Patient 2, Patient 3, Patient 5, Patient 7, Patient 8, Patient 10, Patient 11, Patient 12, Patient 14, Patient 15, Patient 18, Patient 19, Patient 20, Patient 21, Patient 22, Patient 23, Patient 24, Patient 25, Patient 27 and Patient 28), Charge 2 (with respect to these patients) Charge 5 (with respect to Patient 9, 29, 30, 31, 32, 35, 36, 37, 38, 39, 40, 41 and 42) and Charge 6 (with respect to these patients), Charge 7 and Charge 8.
Facts not proved:	Charges 1 (with respect to Patient 4, Patient 6,

	Patient 9, Patient 13, Patient 16, Patient 17 and Patient 26) and Charges 3 and 4 and Charge 5 (with respect to Patients 1, 33 and 34).
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Miss Brown's registered email address by secure email on 23 October 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, date and the fact that this meeting was to be heard virtually.

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

Details of charge

That you, a registered nurse;

1. On dates between September 2021 and March 2022 recorded in the control drug book that fentanyl had been administered to patients in schedule 1 when it had not

2. Your actions at Charge 1 above were dishonest in that you sought to create a misleading impression that fentanyl had been administered when you knew it had not.

3. On 8 January 2022 you signed the controlled drug book in Colleague 1's name without colleague 1's knowledge or permission.

4. Your actions in charge 3 above were dishonest as you knew you were not entitled to sign the controlled drug book on Colleague 1's behalf but you did so anyway.

5. On dates between September 2021 and March 2022 made double entries in the controlled drug book of patients named in schedule 2, by changing their name and/or swapping their first and last name.

6. Your actions in charge 5 above were dishonest as you were aware that these patient names were fabricated and fentanyl had not been administered.

7. Prepared fentanyl incorrectly, in that you prepared it in advance.

8. On dates between September 2021 and March 2022 took medication from the hospital intended for patient use

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

Schedule 1 Patients not given fentanyl but appear in controlled drug book

Patient 1
Patient 2
Patient 3
Patient 4
Patient 5
Patient 6
Patient 7
Patient 8
Patient 9
Patient 10
Patient 11
Patient 12
Patient 13

Patient 14
Patient 15
Patient 16
Patient 17
Patient 18
Patient 19
Patient 20
Patient 21
Patient 22
Patient 23
Patient 24
Patient 25
Patient 26
Patient 27
Patient 28

Schedule 2 (amended)

Patients in bold not given fentanyl as per schedule 1 but appear in controlled drug book
Patient 1
Patient 29
Patient 30
Patient 31
Patient 32
Patient 33

Patient 34
Patient 9
Patient 35
Patient 36
Patient 37
Patient 38
Patient 39
Patient 40
Patient 41
Patient 42

Background

On 11 April 2022, the Nursing and Midwifery Council (NMC) received a referral from Frimley Health NHS Foundation Trust (the Trust), raising concerns about Miss Brown. The charges arose whilst Miss Brown was employed as a registered nurse on the Endoscopy Unit at Wexham Park Hospital (the Hospital).

The Trust reported that between 14 November 2021 and 22 February 2022, Miss Brown had allegedly signed the controlled drugs (CD) book on multiple occasions indicating that Fentanyl had been administered to patients undergoing endoscopy procedures. However, the patient records reportedly documented that these patients had not been given Fentanyl. The Trust further stated that Miss Brown had made double entry records of the same patient, when the patient had only received one dose of Fentanyl. The Trust stated that there were a total of 58 ampoules of Fentanyl that were unaccounted for.

The concerns were reported to the police who concluded that there was no further action to be taken. No further action was taken by the Trust as Miss Brown resigned on 1 August 2022.

Decision and reasons on application to amend the charge

Whilst considering the CD book in relation to Charge 5, the panel noted that the names of Patient 36, Patient 40 and Patient 41 had been misspelt in Schedule 2 of the NMC's Schedule of Charge. The panel considered amending the names in Schedule 2. The proposed amendment was to correct the typographical errors to provide clarity and more accurately reflect the evidence.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Brown and no injustice would be caused to Miss Brown or the NMC by amending the names of the aforementioned patients in Schedule 2. It was therefore appropriate to allow the amendment to ensure clarity and accuracy.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, who referred to the cases of *Ivey v Genting Casinos* [2017] UKSC 67, *Lawrance v General Medical Council* [2015] EWHC 586 (Admin), *Lavis v NMC* [2014] EWHC 4083 (Admin) and *Uddin v GMC* [2012] EWHC 2669 (Admin).

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Colleague 1/Consultant Gastroenterologist at the Hospital at the time of the incidents.

- Witness 2: Clinical Matron at the Hospital at the time of the incidents.

- Witness 3: Junior Sister on the Endoscopy Unit at the Hospital, at the time of the incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC.

The panel drew no adverse inference from the absence of Miss Brown.

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

Charge 1

That you, a registered nurse;

1. On dates between September 2021 and March 2022 recorded in the control drug book that fentanyl had been administered to patients in schedule 1 when it had not

This charge is found proved with respect to Patient 1, Patient 2, Patient 3, Patient 5, Patient 7, Patient 8, Patient 10, Patient 11, Patient 12, Patient 14, Patient 15, Patient 18, Patient 19, Patient 20, Patient 21, Patient 22, Patient 23, Patient 24, Patient 25, Patient 27 and Patient 28.

This charge is found NOT proved with respect to Patient 4, Patient 6, Patient 9, Patient 13, Patient 16, Patient 17 and Patient 26.

In reaching this decision, the panel took into account the documentary evidence of Witness 2, which included her NMC witness statements, the CD books for the Endoscopy Unit, the Endoscopy, Colonoscopy, Sigmoidoscopy and Gastroscopy Reports (documentation completed by a doctor) and Patient Care Pathway Records (documentation completed by a nurse) for the patients referred to below.

The panel had regard to Witness 2's written NMC witness statement dated 10 January 2023, which stated:

> *'I looked at the two CD books from October 2021-February 2022…there were a total of 34 patients that had been signed as being given Fentanyl by the registrant but when I looked at the patient care pathway records and the Endoscopy report and these patients had not been given Fentanyl. In the Endoscopy report the endoscopist writes if Fentanyl has been given…*
>
> *There were also discrepancies with the registrant writing in the CD book that Fentanyl had been given and wasted. An ampoule of Fentanyl is 100mcg but often the endoscopist will only give 50mcg depending on what the patient needs. You cannot use the rest of the Fentanyl for another patient so you have to discard of it. It is not unusual for the rest of the Fentanyl to be discarded but there were multiple patients that were entered and signed by the registrant that she had witnessed that the Fentanyl had been given when it had not…'*

This was confirmed by Witness 2's local witness statement dated 23 February 2022:

> *'I also found after looking back into the CD Books and checking the patient details, that multiple patients that have been recorded as being given fentanyl, when they had not. All of these have been signed by SN Lauren Brown as being given.'*

The panel noted that the copies of the CD book before it, had the name of the medication, Fentanyl, cropped out. However, the panel was satisfied that the copies of the CD book were that of Fentanyl as the dose entries referred to '100mcg' and '50mcg', which is

consistent with Witness 2’s evidence. The panel was convinced that given the dosage and volume of the ampoules described, it could only be Fentanyl that was being recorded.

The panel also considered whether the signatures for the entries in question were that of Miss Brown. Witness 2 confirmed the following in her NMC statement:

> *‘I know it was the registrant as it was her signature. We have a signatory record of all of the nurses and endoscopists that I checked it against….*
> *…I showed her the double entries on the spreadsheet and the CD book at the same time to confirm that it was her signature and she confirmed that it was her signature.’*

In light of the above, the panel was satisfied that the signatures in question belonged to Miss Brown.

The panel then went on to consider Charge 1 with respect to the following patients:

Patient 1

With respect to Patient 1, the panel had regard to the CD book and Patient 1’s Gastroscopy Report. Patient 1’s Patient Care Pathway Record was not before the panel. It noted that on the Gastroscopy Report, it was documented that Patient 1’s procedure had taken place on 8 January 2022 between 09:12 hours and 09:40 hours. Under the section of ‘Premedication’, the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 1 as part of the procedure. The panel found that it could be satisfied from this document that Fentanyl had not been given to this patient on this day even without sight of Patient 1’s Patient Care Pathway Record. This was because the Patient Care Pathway Record and Gastroscopy Report should list identical medications given to the patient.

However, in the CD book, at 13:38 hours on 8 January 2022, it was documented that Patient 1 had been given 50mcg of Fentanyl and that 50mcg had been wasted. Although the panel noted that in the CD book, Patient 1’s name had been inverted, namely her

surname had been written before her forename, it was satisfied that this entry referred to Patient 1.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 1 had been given 50mcg of Fentanyl, when she had not, as evidenced by the Gastroscopy report.

In light of the above, the panel found Charge 1 proved with respect to Patient 1.

Patient 2

The panel had regard to the CD book and Patient 2's Gastroscopy Report. Patient 2's Patient Care Pathway Record was not before the panel. It noted that on the Gastroscopy Report, it was documented that Patient 2's procedure had taken place on 21 November 2021 between 14:45 hours and 15:07 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 2 as part of the procedure. The panel found that it could be satisfied from this document that Fentanyl had not been given to this patient on this day even without sight of Patient 2's Patient Care Pathway Record. This was because the Patient Care Pathway Record and Gastroscopy Report should list identical medications given to the patient.

However, in the CD book, at 14:34 hours on 21 November 2021, it was documented that Patient 2 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 2 had been given 50mcg of Fentanyl, when he had not, as evidenced by the Gastroscopy report. The panel considered that there would have been no reason as to why an entry would have been made for Patient 2 in the CD book, when he had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 2.

Patient 3

The panel had regard to the CD book and Patient 3's Colonoscopy Report. Patient 3's Patient Care Pathway Record was not before the panel. It noted that on the Colonoscopy Report, it was documented that Patient 3's procedure had taken place on 20 February 2022 between 10:33 hours and 11:37 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 3 as part of the procedure.

However, in the CD book, at 10:25 hours on 20 February 2022, two entries of 50mcg had been written but each entry was not specified as either given or wasted.

Despite this, the panel considered the above evidence and was satisfied that Miss Brown had made an entry in the CD book indicating that Patient 3 had been given Fentanyl, when he had not, as evidenced by the Colonoscopy report. The panel considered that there would have been no reason as to why an entry would have been made for Patient 3 in the CD book, when he had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 3.

Patient 4

The panel had regard to the CD book and Patient 4's Colonoscopy Report and Patient Care Pathway Record. It noted that on the Colonoscopy Report, it was documented that Patient 4's procedure had taken place on 8 January 2022 between 15:04 hours and 15:33 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 4 as part of the procedure. This was supported by Patient 4's Patient Care Pathway Record, where under the Drug Record, Fentanyl had not been ticked as a medication that had been administered to Patient 4.

However, in the CD book, at 15:00 hours on 8 January 2022, there were two entries of '50mcg wasted' next to Patient 4's name.

The panel considered the above evidence and determined that although Miss Brown had made a record in the CD book for Patient 4, the entry indicated that 100mcg of Fentanyl (the whole ampoule) had been wasted, and none had been recorded to have been given to Patient 4, which is consistent with the medical records.

In light of the above, the panel found Charge 1 not proved with respect to Patient 4.

Patient 5

The panel had regard to the CD book and Patient 5's Colonoscopy Report and Patient Care Pathway Record. It noted that on the Colonoscopy Report, it was documented that Patient 5's procedure had taken place on 20 November 2021 between 15:03 hours and 15:36 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 5 as part of the procedure.

This was supported by Patient 5's Patient Care Pathway Record, where under the Drug Record, although there was a tick next to Fentanyl, no dose or time had been documented. The panel considered that Fentanyl had not been administered to Patient 5 as it was expected that the dose and time of administration would be documented, similar to Entonox, another drug which had been administered to the patient during the procedure and documented on the Drug Record.

However, in the CD book, at 15:02 hours on 20 November 2021, it was documented that Patient 5 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 5 had been given 50mcg of Fentanyl, when she had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 5 in the CD book, when she had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 5.

Patient 6

The panel had regard to the CD book and Patient 6's Colonoscopy and Gastroscopy Reports and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 6's procedure had taken place on 14 November 2021 between 14:43 hours and 14:52 hours and that his Colonoscopy procedure had taken place on the same day between 14:53 hours and 15:14 hours.

Under the section of 'Premedication' on both records, the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 6 as part of either procedure. This was supported by Patient 6's Patient Care Pathway Record, where under the Drug Record, Fentanyl had not been ticked as a medication that had been administered to Patient 6 for either procedure.

However, in the CD book, at 14:38 hours on 14 November 2021, there were two entries of '50mcg wasted' next to Patient 6's name.

The panel considered the above evidence and determined that although Miss Brown had made a record in the CD book for Patient 6, the entry indicated that 100mcg of Fentanyl (the whole ampoule) had been wasted, and none had been recorded being given to Patient 6, which is consistent with the medical records.

In light of the above, the panel found Charge 1 not proved with respect to Patient 6.

Patient 7

The panel had regard to the CD book and Patient 7's Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 7's procedure had taken place on 21 November 2021 between 10:36 hours and 10:50 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 7 as part of the procedure.

This was supported by Patient 7's Patient Care Pathway Record, where under the Drug Record, Fentanyl had not been ticked as a medication that had been administered to Patient 7.

However, in the CD book, at 10:41 hours on 21 November 2021, it was documented that Patient 7 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 7 had been given 50mcg of Fentanyl, when she had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 7 in the CD book, when she had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 7.

Patient 8

The panel had regard to the CD book and Patient 8's Gastroscopy Report. Patient 8's Patient Care Pathway Record was not before the panel. It noted that on the Gastroscopy Report, it was documented that Patient 8's procedure had taken place on 21 February 2022 between 17:51 hours and 18:01 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 8 as part of the procedure. The panel found that it could be satisfied

from this document that Fentanyl had not been given to this patient on this day even without sight of Patient 8's Patient Care Pathway Record. This was because the Patient Care Pathway Record and Gastroscopy Report should list identical medications given to the patient.

However, in the CD book, at 15:00 hours 20 February 2022, it was documented that Patient 8 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 8 had been given 50mcg of Fentanyl, when she had not, as evidenced by the Gastroscopy Report.

In light of the above, the panel found Charge 1 proved with respect to Patient 8.

Patient 9

The panel had regard to the CD book and Patient 9's Colonoscopy Report. Patient 9's Patient Care Pathway Record was not before the panel. It noted that on the Colonoscopy Report, it was documented that Patient 9's procedure had taken place on 22 February 2022 between 11:11 hours and 11:28 hours. The panel found that it could be satisfied from this document that Fentanyl had not been given to this patient on this day even without sight of Patient 9's Patient Care Pathway Record. This was because the Patient Care Pathway Record and Colonoscopy Report should list identical medications given to the patient.

Under the section of 'Premedication', the panel considered the fact that 50 mcg of Fentanyl had been documented as a medication that was given to Patient 9 as part of the procedure.

In the CD book, at 11:07 hours on 22 February 2022, it was documented that Patient 9 had been given 50mcg of Fentanyl and that 50mcg had been wasted, which was consistent with the Colonoscopy Report.

The panel considered the above evidence and determined that Miss Brown had made a record in the CD book for Patient 9, indicating that 50mcg of Fentanyl had been given to Patient 9, which was correct and again, consistent with the Colonoscopy Report.

In light of the above, the panel found Charge 1 not proved with respect to Patient 9.

Patient 10

The panel had regard to the CD book and Patient 10's Sigmoidoscopy Report and Patient Care Pathway Record. It noted that on the Sigmoidoscopy Report, it was documented that Patient 10's procedure had taken place on 21 November 2021 between 12:53 hours and 13:06 hours. The panel noted that no medication was recorded to have been given to Patient 10 during this procedure. This was supported by Patient 10's Patient Care Pathway Record, where under the Drug Record, Fentanyl, alongside other medications had been crossed out to indicate non-administration.

However, in the CD book, at 12:50 hours on 21 November 2021, it was documented that Patient 10 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 10 had been given 50mcg of Fentanyl, when he had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 10 in the CD book, when he received no medication during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 10.

Patient 11

The panel had regard to the CD book and Patient 11's Sigmoidoscopy Report and Patient Care Pathway Record. It noted that on the Sigmoidoscopy Report, it was documented that

Patient 11’s procedure had taken place on 22 January 2022 between 15:12 hours and 15:19 hours. Under the section of ‘Premedication’, the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 11 as part of the procedure.

This was supported by Patient 11’s Patient Care Pathway Record, where under the Drug Record, Fentanyl had been ticked with a dosage of ‘0mcg’ being given.

However, in the CD book, at 14:35 hours on 22 January 2022, it was documented that Patient 11 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 11 had been given 50mcg of Fentanyl, when she had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 11 in the CD book, when she had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 11.

Patient 12

The panel had regard to the CD book and Patient 12’s Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 12’s procedure had taken place on 8 January 2022 between 10:00 hours and 10:09 hours. Under the section of ‘Premedication’, the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 12 as part of the procedure.

This was supported by Patient 12’s Patient Care Pathway Record, where under the Drug Record, Fentanyl had not been ticked as a medication that had been administered to Patient 12.

However, in the CD book, at 13:15 hours on 8 January 2022, it was documented that Patient 12 had been given 50mcg of Fentanyl and that 50mcg had been wasted. Although the panel noted that in the CD book, Patient 12's name had been inverted, namely his surname had been written before his forename, it was satisfied that this entry referred to Patient 12.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 12 had been given 50mcg of Fentanyl, when he had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 12 in the CD book, when he had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 12.

Patient 13

The panel had regard to the CD book and Patient 13's Sigmoidoscopy Report. Patient 13's Patient Care Pathway Record was not before the panel. It noted that on the Sigmoidoscopy Report, it was documented that Patient 13's procedure had taken place on 15 February 2022 between 14:50 hours and 15:06 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 13 as part of the procedure. The panel found that it could be satisfied from this document that Fentanyl had not been given to this patient on this day even without sight of Patient 9's Patient Care Pathway Record. This was because the Patient Care Pathway Record and Sigmoidoscopy Report should list identical medications given to the patient.

However, in the CD book, at 14:45 hours on 15 February 2022, there were two entries of '50mcg wasted' next to Patient 13's name.

The panel considered the above evidence and determined that although Miss Brown had made a record in the CD book for Patient 13, the entry indicated that 100mcg of Fentanyl (the whole ampoule) had been wasted, and none had been recorded to have been given to Patient 13, which is consistent with the Sigmoidoscopy Report.

In light of the above, the panel found Charge 1 not proved with respect to Patient 13.

Patient 14

The panel had regard to the CD book and Patient 14's Colonoscopy Report and Patient Care Pathway Record. It noted that on the Colonoscopy Report, it was documented that Patient 14's procedure had taken place on 21 November 2021 between 15:43 hours and 16:14 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 14 as part of the procedure.

This was supported by Patient 14's Patient Care Pathway Record, where under the Drug Record, Fentanyl had been crossed out, indicating that it had not been administered to Patient 14 during the procedure.

However, in the CD book, at 15:40 hours on 21 November 2021, it was documented that Patient 14 had been given 50mcg of Fentanyl and that 50mcg had been wasted. Although the panel noted that in the CD book, Patient 14's name had been inverted, it was satisfied that this entry referred to Patient 14.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 14 had been given 50mcg of Fentanyl, when he had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 14 in the CD book, when he had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 14.

Patient 15

The panel had regard to the CD book and Patient 15's Sigmoidoscopy Report and Patient Care Pathway Record. It noted that on the Sigmoidoscopy Report, it was documented that Patient 15's procedure had taken place on 8 January 2022 between 11:20 hours and 11:56 hours. The panel noted that no medication was recorded to have been given to Patient 15 during this procedure. This was supported by Patient 15's Patient Care Pathway Record, where under the Drug Record, no medications were recorded to have been given during the procedure.

However, in the CD book, at 11:17 hours on 8 January 2022, it was documented that Patient 15 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 15 had been given 50mcg of Fentanyl, when he had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 15 in the CD book, when he received no medication during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 15.

Patient 16

The panel had regard to the CD book and Patient 16's Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 16's procedure had taken place on 21 November 2021 between 11:34 hours and 12:05 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 16 as part of the procedure.

This was supported by Patient 16’s Patient Care Pathway Record, where under the Drug Record, Fentanyl had not been recorded as a medication that had been administered to Patient 16 during the procedure.

However, in the CD book, at 12:00 hours on 21 November 2021, the entry ‘100mcg wasted (not needed)’ was made next to Patient 16’s name.

The panel considered the above evidence and determined that although Miss Brown had made a record in the CD book for Patient 16, the entry indicated that 100mcg of Fentanyl had been wasted as it was not needed. The panel considered this to be consistent with Patient 16’s medical records, which indicated that Fentanyl was not administered.

In light of the above, the panel found Charge 1 not proved with respect to Patient 16.

Patient 17

The panel had regard to the CD book and Patient 17’s Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 17’s procedure had taken place on 22 January 2022 between 15:25 hours and 15:38 hours. Under the section of ‘Premedication’, the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 17 as part of the procedure.

This was supported by Patient 17’s Patient Care Pathway Record, where the Drug Record had been crossed out and no medications had been documented as given.

However, in the CD book, at 15:20 hours on 22 January 2022, there were two entries of ‘50mcg wasted’ next to Patient 17’s name.

The panel considered the above evidence and determined that although Miss Brown had made a record in the CD book for Patient 17, the entry indicated that the whole Fentanyl ampoule had been wasted, and none had been recorded to have been given to Patient 17, which is consistent with the medical records.

In light of the above, the panel found Charge 1 not proved with respect to Patient 17.

Patient 18

The panel had regard to the CD book and Patient 18's Gastroscopy Report. Patient 18's Patient Care Pathway Record was not before the panel. It noted that on the Gastroscopy Report, it was documented that Patient 18's procedure had taken place on 20 February 2022 between 15:40 hours and 15:57 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 18 as part of the procedure. The panel found that it could be satisfied from this document that Fentanyl had not been given to this patient on this day even without sight of Patient 18's Patient Care Pathway Record. This was because the Patient Care Pathway Record and Gastroscopy Report should list identical medications given to the patient.

However, in the CD book, at 15:15 hours on 20 February 2022, it was documented that Patient 18 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 18 had been given 50mcg of Fentanyl, when she had not, as evidenced by the Gastroscopy Report. The panel considered that there would have been no reason as to why an entry would have been made for Patient 18 in the CD book, when she had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 18.

Patient 19

The panel had regard to the CD book and Patient 18's Sigmoidoscopy Report and Patient Care Pathway Record. It noted that on the Sigmoidoscopy Report, it was documented that Patient 19's procedure had taken place on 25 January 2022 between 10:25 hours and 10:36 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 19 as part of the procedure.

This was supported by Patient 19's Patient Care Pathway Record, where Fentanyl had not been recorded on the Drug Record as a medication that had been administered to Patient 19 during the procedure.

However, in the CD book, at 10:25 hours on 25 January 2022, it was documented that Patient 19 had been given 50mcg of Fentanyl and that 50mcg had been disposed of.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 19 had been given 50mcg of Fentanyl, when he had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 19 in the CD book, when he had not been administered Fentanyl during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 19.

Patient 20

The panel had regard to the CD book and Patient 20's Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 20's procedure had taken place on 30 January 2022 between 13:52 hours and 14:01 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 20 as part of the procedure.

This was supported by Patient 20's Patient Care Pathway Record, where Fentanyl had not been recorded on the Drug Record as a medication that had been administered to Patient 20 during the procedure.

However, in the CD book, at 16:20 hours on 30 January 2022, it was documented that Patient 20 had been given 25mcg of Fentanyl and that 75mcg had been disposed of.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 20 had been given 50mcg of Fentanyl, when he had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 20 in the CD book, over two hours after the procedure had concluded, when Fentanyl had not been administered during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 20.

Patient 21

The panel had regard to the CD book and Patient 21's Sigmoidoscopy Report and Patient Care Pathway Record. It noted that on the Sigmoidoscopy Report, it was documented that Patient 21's procedure had taken place on 30 January 2022 between 14:10 hours and 14:25 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 21 as part of the procedure.

This was supported by Patient 21's Patient Care Pathway Record, where Fentanyl had not been recorded on the Drug Record as a medication that had been administered to Patient 21 during the procedure.

However, in the CD book, at 15:30 hours on 30 January 2022, it was documented that Patient 21 had been given 100mcg of Fentanyl.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 21 had been given 100mcg of Fentanyl, which was contrary to Patient 21's medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 21 in the CD book, when Fentanyl had not been administered during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 21.

Patient 22

The panel had regard to the CD book and Patient 22's Sigmoidoscopy Report and Patient Care Pathway Record. It noted that on the Sigmoidoscopy Report, it was documented that Patient 22's procedure had taken place on 16 January 2022 between 15:34 hours and 15:48 hours. The panel noted that no medication was recorded to have been given to Patient 22 during this procedure. This was supported by Patient 22's Patient Care Pathway Record, where no medications were recorded to have been administered on the Drug Record.

However, in the CD book, at 14:38 hours on 16 January 2022, it was documented that Patient 22 had been given 50mcg of Fentanyl and that 50mcg had been disposed of.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 22 had been given 50mcg of Fentanyl, when he had not, as evidenced by the medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 22 in the CD book, when he received no medication during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 22.

Patient 23

The panel had regard to the CD book and Patient 23's Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 23's procedure had taken place on 25 January 2022 between 15:31 hours and 15:53 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 23 as part of the procedure.

This was supported by Patient 23's Patient Care Pathway Record, where Fentanyl had not been recorded on the Drug Record as a medication that had been administered to Patient 23 during the procedure.

However, in the CD book, at 15:22 hours on 25 January 2022, it was documented that Patient 23 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 23 had been given 50mcg of Fentanyl, which was contrary to Patient 23's medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 23 in the CD book, when Fentanyl had not been administered during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 23.

Patient 24

The panel had regard to the CD book and Patient 24's Sigmoidoscopy Report and Patient Care Pathway Record. It noted that on the Sigmoidoscopy Report, it was documented that Patient 24's procedure had taken place on 30 January 2022 between 14:31 hours and 14:56 hours. The panel noted that Patient 24 did not have any medications administered during the course of the procedure.

This was supported by Patient 24's Patient Care Pathway Record, where no medications were recorded on the Drugs Record to have been administered to Patient 24 during the procedure.

However, in the CD book, at 15:05 hours on 30 January 2022, it was documented that Patient 24 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 24 had been given 50mcg of Fentanyl, which was contrary to Patient 24's medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 24 in the CD book, when Fentanyl had not been administered during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 24.

Patient 25

The panel had regard to the CD book and Patient 25's Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 24's procedure had taken place on 25 January 2022 between 12:01 hours and 12:14 hours.

Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 25 as part of the procedure.

This was supported by Patient 25's Patient Care Pathway Record, where Fentanyl had not been recorded on the Drug Record as a medication that had been administered to Patient 25 during the procedure.

However, in the CD book, at 11:30 hours on 25 January 2022, it was documented that Patient 25 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 25 had been given 50mcg of Fentanyl, which was contrary to Patient 25's medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 25 in the CD book, when Fentanyl had not been administered during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 25.

Patient 26

The panel had regard to the CD book and Patient 26's Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 26's procedure had taken place on 1 February 2022 between 10:23 hours and 10:47 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 26 as part of the procedure.

This was supported by Patient 26's Patient Care Pathway Record, where under the Drug Record, Fentanyl had been ticked but the dosage and time entries were incomplete. The panel considered that this incomplete entry indicated that Fentanyl had not been administered to Patient 26 during the procedure.

Nonetheless, in the CD book, at 10:30 hours on 1 February 2022, there were two entries of '50mcg wasted' next to Patient 26's name.

The panel considered the above evidence and determined that although Miss Brown had made a record in the CD book for Patient 26, the entry indicated that 100mcg of Fentanyl had been wasted. The panel considered this to be consistent with Patient 26's medical records, which indicated that Fentanyl was not administered.

In light of the above, the panel found Charge 1 not proved with respect to Patient 26.

Patient 27

The panel had regard to the CD book and Patient 27's Gastroscopy Report and Patient Care Pathway Record. It noted that on the Gastroscopy Report, it was documented that Patient 27's procedure had taken place on 25 January 2022 between 10:41 hours and 10:52 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 27 as part of the procedure.

This was supported by Patient 27's Patient Care Pathway Record, where Fentanyl had not been recorded on the Drug Record as a medication that had been administered to Patient 27 during the procedure.

Nonetheless, in the CD book, at 10:42 hours on 25 January 2022, it was documented that Patient 27 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 27 had been given 50mcg of Fentanyl, which was contrary to Patient 27's medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 27 in the CD book, when Fentanyl had not been administered during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 27.

Patient 28

The panel had regard to the CD book and Patient 28's Sigmoidoscopy Report. Patient 28's Patient Care Pathway Record was not before the panel. It noted that on the Sigmoidoscopy Report, it was documented that Patient 28's procedure had taken place on 25 January 2022 between 12:53 hours and 13:04 hours. Under the section of 'Premedication', the panel considered the fact that Fentanyl had not been documented as a medication that was given to Patient 28 as part of the procedure. The panel found that it

could be satisfied from this document that Fentanyl had not been given to this patient on this day even without sight of Patient 28's Patient Care Pathway Record. This was because the Patient Care Pathway Record and Sigmoidoscopy Report should list identical medications given to the patient.

Nonetheless, in the CD book, at 12:55 hours on 25 January 2022, it was documented that Patient 28 had been given 50mcg of Fentanyl and that 50mcg had been wasted.

The panel considered the above evidence and determined that Miss Brown had recorded in the CD book that Patient 28 had been given 50mcg of Fentanyl, which was contrary to Patient 28's medical records. The panel considered that there would have been no reason as to why an entry would have been made for Patient 28 in the CD book, when Fentanyl had not been administered during the procedure.

In light of the above, the panel found Charge 1 proved with respect to Patient 28.

Charge 2

That you, a registered nurse;

2. Your actions at Charge 1 above were dishonest in that you sought to create a misleading impression that fentanyl had been administered when you knew it had not.

This charge is found proved.

In reaching this decision, the panel considered its findings with respect to Charge 1.

It first considered whether there were reasonable alternative explanations for the discrepancies identified in Charge 1.

The panel noted that there were entries made by Miss Brown within the CD book that did not correspond with the patients' medical records, especially the Patient Care Pathway Records, specifically the Drug Record completed for the patient at the time of the procedures.

The panel considered whether the discrepancies may have been due to Miss Brown's lack of knowledge on how to complete entries in a CD book. The panel was not satisfied that this was a reasonable explanation as there were examples of entries within the CD book that had been completed correctly by Miss Brown. Furthermore, the panel noted that Miss Brown was described by Witness 2 as a competent and experienced Band 5 nurse, who knew the controlled drugs policy and would have been competent to administer controlled drugs:

> *'The registrant was IV competent and an experienced nurse and we had a clear CD policy. She would have known not to sign that Fentanyl had been given when it had not, it was very concerning for me.'*

The panel noted that it appeared that Miss Brown did know how to complete a CD book and that the discrepancies identified in Charge 1 were likely to have been deliberate.

The panel next considered whether the discrepancies in the CD book may have been as a result of Miss Brown rushing due to a busy work environment. The panel noted that there were minimal omissions, errors or crossings out in the documentation within the book. It was of the view that if the discrepancies were as a result of being rushed, it would be likely that there would be multiple mistakes, including incorrect dates and tally errors in the daily CD count. However, the panel noted that the figures within the CD book were internally consistent, the wasted and given amounts always added up to 100mcg per ampoule and the tally was always consistent. The panel also found that it was unlikely that there would have been this many incorrect entries if it was a case of genuine error. The panel considered the recording of entries was not done in error. It concluded that Miss Brown knew what she was doing.

Having established this, the panel went on to consider whether Miss Brown's actions in Charge 1 were dishonest. It had regard to the test set out in *Ivey v Genting Casinos,* which outlines the following*:*

- What was the defendant's actual state of knowledge or belief as to the facts; and
- Was the conduct dishonest by the standards of ordinary decent people?

The panel considered that Miss Brown was aware that Fentanyl had not been administered to most of the patients in Charge 1 and that she knew that she had been incorrectly recording administered doses in the CD book. The panel noted that it had no evidence before it from Miss Brown providing any alternative explanation for the discrepancies and that the contemporaneous medical records before it ruled out any other likely explanations. The panel also considered that ordinary decent people would expect that a registrant would not deliberately inaccurately record medications administered. In light of this, the panel concluded that Miss Brown wished to create a misleading impression that Fentanyl had been administered when she knew she had not. The panel concluded that this would be considered dishonest by the standards of ordinary decent people.

The panel therefore found Charge 2 proved.

Charge 3

That you, a registered nurse;

3. On 8 January 2022 you signed the controlled drug book in Colleague 1's name without colleague 1's knowledge or permission.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 1 and Witness 2 and the CD book.

In her witness statement, Witness 2 stated:

> *'I asked two endoscopists, [Colleague 2] and [Colleague 1], why they had signed that Fentanyl had been given when it had not as there were 7 patients that had been signed by the endoscopist and by the registrant. I showed them the CD Book and both endoscopists confirmed that they had not signed it. The registrant must have forged the signature as it was her signature on the witness signature that the Fentanyl had been given and she was the nurse in the room responsible for recording the medication.'*

The panel had regard to the entries for Fentanyl in the CD book for 8 January 2022. It noted that Miss Brown's signature was clear within the 'Witnessed by' column and a 'squiggled' signature was within the 'Given by' column.

In his NMC written statement dated 12 January 2023, Witness 1 stated:

> *'I was approached by [Witness 2] to double check the controlled drugs book for my patients. [Witness 2] asked me to review it to see whether I had signed the controlled book for some of the patients. I reviewed the book and I double cheeked [sic] that the patients listed were my patients and they were but the signature in the book was not mine. I know my signature and the signature in the book next to my patients was not mine so I assume someone else signed it…'*

This was confirmed by an email sent by Witness 1 to Witness 2 on 7 April 2022:

> *'I reviewed control drug medication administration signatures you sent. I noted on 8/1/2022, there are signatures of drug administration for patients I did but signed by someone else...'*

The panel noted that Witness 2, during a local investigation meeting on 8 April 2022 reported:

> *'I showed her the two Endoscopists CD book signatures that she had signed to say she had witnessed it and asked her if she had forged the signature and she said*

that she didn't understand and that there were always people in the room… She didn't admit to forging the Endoscopists signatures.'

The panel considered the above evidence and determined that the signature in the 'Given by' column for 8 January 2022, did not belong to Colleague 1. However, it had no evidence before it to ascertain what Colleague 1's signature was supposed to look like and whether the signature in the CD book was an imitation or forgery of this signature. Although, the panel was satisfied from Colleague 1's evidence that the signatures next to Miss Brown's own in the CD book were not his, it could not be satisfied that the signature had been signed in Colleague 1's name.

In light of the above, the panel found Charge 3 not proved.

Charge 4

That you, a registered nurse;

4. Your actions in charge 3 above were dishonest as you knew you were not entitled to sign the controlled drug book on Colleague 1's behalf but you did so anyway.

This charge is found NOT proved.

In reaching this decision, the panel considered its findings with respect to Charge 3.

The panel found that since Charge 4 stems from Charge 3, which has been found not proved, it could not find Charge 4 proved.

Accordingly, this charge has been found not proved.

Charge 5

That you, a registered nurse;

5. On dates between September 2021 and March 2022 made double entries in the controlled drug book of patients named in schedule 2, by changing their name and/or swapping their first and last name.

This charge is found proved with respect to Patient 9, Patient 29, Patient 30, Patient 31, Patient 32, Patient 35, Patient 36, Patient 37, Patient 38, Patient 39, Patient 40, Patient 41 and Patient 42

This charge is found NOT proved with respect to Patient 1, Patient 33 and Patient 34.

In reaching this decision, the panel took into account the documentary evidence of Witness 2, which included her NMC witness statements and the CD book entries for the patients referred to below and the documentary evidence of Witness 3.

The panel had regard to Witness 2's written NMC witness statement which stated:

> *'…on the 22 February 2022 [Witness 3] had found some discrepancies in the controlled drugs (CD) book. The discrepancies were that there had been double entries of patients where they were entered once and then a second time but with the first and last name swapped round. It was the registrant's signature on the CD book.'*

Witness 3 had also stated the following in her written NMC witness statement:

> *'…I went to check the CD book again and I found that Lauren had recorded a patient twice. She had put the first and last name of the patient in the book and had written that 50mg of Fentanyl had been given and then 50mg of Fentanyl had been wasted. Then at the bottom of the CD book she had written the same patients name but just swapped the first and last name around. I can't remember the name of the patient but for example, the first patient was John Lewis and the second patient she recorded was Lewis John. I was so shocked when I saw she had done this. Again, I knew it was Lauren as it was her signature. I checked the other procedure room's*

CD book as we have two procedure rooms and she had also done this several times in that book.'

This was further supported by Witness 3's local witness statement:

'…After this I felt I needed to re-check the CD medication book in both procedure rooms in GI Unit. They both were correct numbers however looking back at the documentation there was mistakes that was noticed [sic]. For example, double entries of patients…'

Further to its findings in Charge 1, the panel was satisfied that the signatures in question belonged to Miss Brown.

The panel considered Charge 5 with respect to the following patients:

Patient 1

With respect to Patient 1, the panel had regard to the CD book. It noted that at 13:38 on 8 January 2022, Patient 1's name had been documented, but her name had been inverted namely, her surname had been written before her forename. But the panel also noted that this was the only entry for Patient 1 made in the CD book.

In light of the above, the panel was satisfied that although Patient 1's name had been swapped, a double entry had not been made. The panel therefore found Charge 5 not proved with respect to Patient 1.

Patient 29

With respect to Patient 29, the panel had regard to the CD book. It noted that at 15:22 on 14 November 2021, Patient 29's name had been documented. But again in the box below with the time 15:22, Patient 29's name had been recorded again however, this time, it had been inverted namely, his surname had been written before his forename.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 29 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 29.

Patient 30

With respect to Patient 30, the panel had regard to the CD book. It noted that at 12:03 on 19 February 2022, Patient 30's name had been documented. But again at 12:15, Patient 30's name had been recorded however, this time, it had been inverted.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 30 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 30.

Patient 31

With respect to Patient 31, the panel had regard to the CD book. It noted that at 09:01 on 16 December 2021, Patient 31's name had been documented. But again at 10:50, Patient 31's name had been recorded however, this time, it had been inverted.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 31 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 31.

Patient 32

With respect to Patient 32, the panel had regard to the CD book. It noted that at 15:35 on 22 January 2022, Patient 32's name had been documented. But again at 16:00, Patient 32's name had been recorded however, this time, it had been inverted.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 32 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 32.

Patient 33

With respect to Patient 33, the panel had regard to the CD book. It noted that at 11:00 on 15 February 2022, Patient 33's name had been documented correctly in the CD book. However, in the box below at 11:30, Patient 33's name had been recorded again, but it had not been swapped.

In light of the above, the panel was satisfied that although Patient 33's name had been entered twice, it had not been changed or swapped. The panel therefore found Charge 5 not proved with respect to Patient 33.

Patient 34

With respect to Patient 34, the panel had regard to the CD book. It noted that at 10:15 on 19 February 2022, Patient 34's name had been documented correctly in the CD book. However, in the box below at 10:20, Patient 34's name had been recorded again, but it had not been swapped.

In light of the above, the panel was satisfied that although Patient 34's name had been entered twice in a short space of time, it had not been changed or swapped. The panel therefore found Charge 5 not proved with respect to Patient 34.

Patient 9

With respect to Patient 9, the panel had regard to the CD book. It noted that at 11:07 on 22 February 2022, Patient 9's name had been documented. But again at 11:30, Patient 9's name had been recorded however, this time, it had been inverted.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 9 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 9.

Patient 35

With respect to Patient 35, the panel had regard to the CD book. It noted that at 12:54 on 23 January 2022, Patient 35's name had been documented. But again at 13:00, Patient 35's name had been recorded however, this time, it had been inverted.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 35 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 35.

Patient 36

With respect to Patient 36, the panel had regard to the CD book. It noted that at 11:40 on 20 February 2022, Patient 36’s name had been documented. But again at 12:30, Patient 36’s name had been recorded however, this time, it had been inverted.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 36 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 36.

Patient 37

With respect to Patient 37, the panel had regard to the CD book. It noted that at 14:45 on 20 February 2022, Patient 37’s name had been documented. But again at 15:30, Patient 37’s name had been recorded however, this time, it had been swapped.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 37 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 37.

Patient 38

With respect to Patient 38, the panel had regard to the CD book. It noted that at 11:30 on 22 February 2022, Patient 38’s name had been documented. But again at 12:39, Patient 38’s name had been recorded however, this time, it had been changed to a variation of his surname.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 38 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when the whole of the first ampoule was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 38.

Patient 39

With respect to Patient 39, the panel had regard to the CD book. It noted that at 16:31 on 15 February 2022, Patient 39's name had been documented. But again at 16:45, Patient 39's name had been recorded however, this time, it had been swapped.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 39 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 39.

Patient 40

With respect to Patient 40, the panel had regard to the CD book. It noted that at 12:55 on 8 January 2022, Patient 40's name had been documented. But again at 15:30, Patient 40's name had been recorded however, this time, it had been swapped and changed.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 40 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 40.

Patient 41

With respect to Patient 41, the panel had regard to the CD book. It noted that at 10:00 on 25 January 2022, Patient 41's name had been documented. But again at 16:00, Patient 41's name had been recorded however, this time, it had been swapped.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 41 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 41.

Patient 42

With respect to Patient 42, the panel had regard to the CD book. It noted that at 14:55 on 30 January 2022, Patient 42's name had been documented. But again at 16:45, Patient 42's name had been recorded however, this time, it had been swapped.

The panel considered the above evidence and it determined that Miss Brown had made a double entry in the CD book for Patient 42 and that his name had been swapped. The panel concluded that it was unlikely the entries were in relation to two separate patients with a similar name and that it was also unlikely that the same patient would require two separate ampoules of Fentanyl to be removed, when a portion of each was wasted.

In light of the above, the panel found Charge 5 proved with respect to Patient 42.

Charge 6

That you, a registered nurse;

6. Your actions in charge 5 above were dishonest as you were aware that these patient names were fabricated and fentanyl had not been administered.

This charge is found proved.

In reaching this decision, the panel considered its findings with respect to Charge 6 and the case of *Ivey v Genting Casinos*.

The panel considered that Miss Brown was aware that she had duplicated patient names in the CD book, especially since some of the duplicated entries were made soon after the initial entry. The panel considered that if a patient required a second dose of Fentanyl, it would be reasonable to assume that the patient's name would be copied from the previous entry, as opposed to the first and last name being switched. As a result, on the balance of probabilities, considering the findings made in relation to Charge 5, Miss Brown knowingly altered the names of known patients to give the impression that they were new patients and that there were no reasonable explanations for this change. In light of this, the panel concluded that Miss Brown's conduct would be considered dishonest by the standards of ordinary decent people.

The panel therefore found Charge 6 proved.

Charge 7

That you, a registered nurse;

7. Prepared fentanyl incorrectly, in that you prepared it in advance.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 1 and Witness 3 and the Trust's Controlled Drugs Policy.

In her written NMC witness statement dated 22 November 2022, Witness 3 stated the following:

> *'…there was an incident where Lauren had prepared a few ampoules of Fentanyl and the other staff nurse…called me and said that Lauren had prepared it in advance. I went to see and there were about three syringes of Fentanyl on the table. I called Lauren and said that we don't prepare Fentanyl in advance and she knew this and she apologised. I can't remember what her explanation was for preparing it in advance I just remember that she apologised and said she wouldn't do it again. I told her that she should know not to do this…'*

This was supported by her local witness statement with respect to an incident that occurred on 22 February 2022, in which she stated:

> *'…This is not the first occasion that this has occurred with RN LB as I have had a previous experience where this same individual had pre-drawn controlled drug medication in advance (Multiple drawn) where I have seen this.'*

Witness 1 also confirmed the following in his NMC witness statement:

> *'The sedation (Fentanyl) is only prepared in the endoscopy room once the patient has decided that they want it. This is when the nurse draws up the medication and I am not aware that they would do this prior to being in the procedure room.'*

The panel considered the above evidence. It noted that although the Trust's Controlled Drugs Policy did not explicitly state that controlled drugs such as Fentanyl cannot or should not be prepared in advance, it was considered poor practice to do so. The panel acknowledged that Witness 1 (a Consultant Gastroenterologist) and Witness 3 (a Junior Sister), were experienced members of staff who were more senior to Miss Brown, and the panel considered them to be reliable in their descriptions of what is considered to be good practice. The panel also noted that when she was challenged, Miss Brown had apologised for preparing Fentanyl in advance and had promised to not do it again.

In light of the above, the panel was satisfied that Miss Brown had prepared Fentanyl incorrectly by preparing it in advance.

Accordingly, the panel found Charge 7 proved.

Charge 8

That you, a registered nurse;

8. On dates between September 2021 and March 2022 took medication from the hospital intended for patient use

This charge is found proved.

As a result of the findings of fact in relation to the earlier charges found proved, the panel concluded on the balance of probabilities that Miss Brown took medication intended for patients from the hospital.

In light of this, the panel found Charge 8 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 Miss Brown's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Representations on misconduct and impairment

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

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the following representation from the NMC:

> '***Misconduct***
> *13. It is submitted that the facts amount to misconduct*
>
> *14. Whether the facts found proved amount to misconduct is a matter entirely for the panel's professional judgment. There is no burden or standard of proof (per Council for the Regulation of Health Care Professionals v (1) General Medical Council (2) Biswas [2006] EWHC 464 (Admin)).*
>
> *15. In Roylance v General Medical Council [1999] UKPC 16 the comments of Lord Clyde may provide some assistance when seeking to define misconduct:*
>
>> *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.*
>
> *16. Similarly, the comments of Jackson J in Calhaem v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317*

(Admin), respectively add that:

> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.*

And

> *'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.*

17.Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct, 'Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code").

18.On the basis of the charges being found proved, it is submitted, that the following parts of the Code are engaged in this case:

10 Keep clear and accurate records relevant to your practice
To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times,
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.4 keep to the laws of the country in which you are practising
20.8 act as a role model of professional behaviour for students and newly

qualified nurses, midwives and nursing associates to aspire to

19. It is submitted that Miss Brown's conduct as detailed in the charges laid out at paragraph 2 above have fallen far short of what is and would have been expected of a registered professional. It is a serious breach of professional conduct, amounting to an abuse of her role and access to medication afforded to a nurse. Her conduct would no doubt be seen as deplorable by her fellow practitioners and would damage the trust that the public places in the profession. As such, it must amount to misconduct.

Impairment

20. It is submitted that Miss Brown's fitness to practise is impaired by reason of her misconduct on both public interest and public protection grounds.

21. Impairment needs to be considered as of today's date, i.e. whether Miss Brown's fitness to practise is currently impaired as a result of her misconduct. The NMC defines impairment as a Registrant's suitability to remain on the register without restriction. There is no burden or standard of proof to apply as this is a matter for the fitness to practice panel's own professional judgement….'

The NMC outlined NMC Guidance with respect to Impairment (*reference DMA-1*) and the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin)) and submitted the following:

'26. In this case, it is submitted that all limbs of Grant are fully engaged.

27. Although there was no direct evidence of actual harm to patients, the act of taking of drugs intended for patient use, particularly coupled with the falsification of records in order to conceal that act, does suggest that Miss Brown has in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm. Miss Brown's colleagues rely on accurate records to make effective decisions about the care of patients. False records could lead to

patients being administered incorrect doses of drugs, exposing them to unwarranted risks either of overdose or unnecessary levels of pain. Furthermore, where a drug like Fentanyl appears to have been administered when it fact it has not, patients may be denied medication they need because it cannot ordinarily be combined with Fentanyl.

…

29. Miss Brown has brought the profession into disrepute by the very nature of her conduct and dishonesty displayed in relation to that conduct. Nurses occupy a position of trust and must act with, and promote integrity at all times. Professionalism and integrity are fundamental tenets of the profession that have been breached in this case. The public has the right to expect high standards of registered professionals. The seriousness and extent of Miss Brown's conduct are such that it calls into question her professionalism in the workplace as she used her position as a registered nurse to access controlled drugs and falsify records in order to conceal taking of medication from her employer. This has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute.

30. The taking of any drugs, and particularly of controlled drugs, from the workplace is behaviour that is not consistent with that expected of a registered nurse. Miss Brown's conduct is fundamentally incompatible with being a registered professional because the qualities required of Miss Brown have been significantly undermined and compromised.

31. With regard to future risk, it may assist to consider the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) namely (i) whether the concerns are easily remediable; (ii) whether they have in fact been remedied; and (iii) whether they are highly unlikely to be repeated.

32. Miss Brown has provided no insight and shown no remorse into the misconduct and not engaged with the NMC's investigation. Furthermore, our guidance entitled 'How we determine seriousness' explains that there are certain concerns, including those about dishonesty, that are more difficult to put right and often

mean that the nurse, midwife or nursing associate's right to practice needs to be restricted. We therefore submit that there remains a clear continuing risk to the public due to the complete absence of any insight or remorse into the seriousness of the misconduct. A finding of impairment is therefore necessary on public interest and public protection grounds.'

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, *Grant* and *Cheatle v GMC* [2009] EWHC 645 (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: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2015) (the Code).

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

*'**10 Keep clear and accurate records relevant to your practice***
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
…
***10.3** 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*
…

20 Uphold the reputation of your profession at all times
To achieve this, you must:
…
***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. However, the panel was of the view that Miss Brown's actions did fall far below the standards expected of a registered nurse. The panel considered that Miss Brown's dishonesty and fabrication of patient details was serious and involved elements of careful planning. Although there is no evidence that actual harm was caused, there was a risk of harm to patients. The panel acknowledged that Fentanyl is a potent opiate drug, and by removing it from the drugs cupboard for uses outside of patient administration, Miss Brown would have placed patients and the public at a risk of harm, as Fentanyl, a controlled drug, would no longer be controlled. In addition, by falsifying patient details in the CD book, Miss Brown would have created a misleading impression that a patient had received a medication, when they had not, and this could have had an impact on their ongoing care and management of their treatment.

The panel found that Miss Brown'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, Miss Brown's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library (*reference DMA-1*), updated on 27 February 2024, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel concluded that limbs a, b, c and d of the *Grant* test are engaged in this case, both in the past and in the future. The panel found that although no actual harm was caused as a result of Miss Brown's misconduct, patients were put at a risk of harm from her dishonesty and falsification of patient details. The panel also concluded that Miss Brown's misconduct had breached the fundamental tenets of the nursing profession and had therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel was aware that this is a forward-looking exercise, and accordingly it went on to consider whether Miss Brown's misconduct was remediable and whether she has already remediated her misconduct.

The panel had concerns about deep-seated attitudinal issues with respect to Miss Brown's misconduct. Not only had Miss Brown dishonestly fabricated patient information to remove Fentanyl for other purposes, but this conduct had been meticulously undertaken and had occurred over a prolonged period of time, on multiple occasions. The panel was of the view that this made the dishonesty more significant. The panel determined that Miss Brown's misconduct was so serious that it would be difficult to remediate.

Accordingly, the panel went on to consider whether Miss Brown remained liable to act in a way that would put patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

Regarding insight, the panel considered that there was no evidence before it, such as a written reflective piece, to demonstrate Miss Brown's insight, any attempts of remediation or strengthened practice. The panel also had no information before it regarding Miss Brown's current employment or whether she wishes to continue to practise as a registered nurse.

The panel was of the view that there is a risk of repetition based on the fact that Miss Brown has not engaged with the NMC and has not demonstrated any insight or remediation. In the panel's judgement, due to Miss Brown's lack of insight and recognition of the seriousness of her actions, there remains 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 that the overarching objectives of the NMC are 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 a finding of impairment on public interest grounds is also required as members of the public would be alarmed to learn that Fentanyl, a highly potent opiate drug, had been misappropriated by a registered nurse, who has a responsibility ensure that controlled drugs are properly managed and administered. The panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case. It therefore found Miss Brown's fitness to practise also impaired on the grounds of public interest.

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

Sanction

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

In reaching this decision, the panel 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.

Representations on sanction

The panel noted that in the Notice of Meeting, the NMC had advised Miss Brown that it would seek the imposition of a striking off order if it found Miss Brown's fitness to practise currently impaired.

The NMC invited the panel consider a striking-off order as the most appropriate sanction in this case. It referred to the SG (reference SAN- 3e), which states:

> *'A striking off order is likely to be appropriate when what the registrant has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*
>
> - *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
> - *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate 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 NMC also referred to NMC Guidance entitled *'Considering sanctions for serious cases'* and made the following submissions:

> *'…allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. This is particularly true where there have been deliberate breeches of professional duty of candour by covering up when things have gone wrong, and where the professional has been engaged in deception that is premeditated, systematic or longstanding in nature.*
>
> *38. Miss Brown has provided no insight into the charges she faces. It is submitted that she had been taking medication for a considerable amount of time which demonstrates serious dishonesty that is very difficult to remediate. This is*

compounded by the fact that a degree of planning went into concealing her actions through falsified records.

39.Considering each sanction in turn starting with the least restrictive:

a. Taking no further action would not adequately deal with the seriousness of the concerns in this case and would not meet the wider public interest.

b. A Caution Order would be insufficient to maintain public confidence within the profession and would be inadequate to mark the seriousness of the conduct displayed in this case.

c. A Conditions of Practice Order would be inappropriate because there are no conditions that would be sufficient to maintain confidence within the profession. In addition, the mischief in this case is not such that it can be addressed through conditional registration. Furthermore the charges are not in relation to a clinical matter which can be improved through a period of conditional registration. Whilst a conditions of practice order could address issues of handling of medication, these charges are inextricably linked to the charges of theft, which are too serious for conditions alone.

d. A suspension order would be inappropriate as there is evidence of deep-seated attitudinal and personality problems and the Registrant's conduct could be seen as a pattern of repeated dishonesty which occurred over a significant period of time, and so it can't be said to be a single instance of misconduct.

40. The appropriate and proportionate sanction is one of a striking off order. Miss Brown has brought the profession into disrepute and trust and confidence in the profession is likely to be seriously eroded by the fact that Miss Brown's behaviour raises fundamental questions as a registered professional and is incompatible with continued registration. The concerns are difficult to address or put right and constitute a serious breach of professional boundaries.

41. A striking off order is the only order that would adequately meet the public interest by declaring such behaviour as unacceptable for a registered professional.'

Decision and reasons on sanction

Having found Miss Brown's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel bore 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:

- Abuse of a position of trust and power as a registered nurse responsible for managing controlled drugs.
- Lack of evidence of insight into failings
- A pattern of misconduct over a period of time
- A level of sophistication in the dishonest behaviour
- Risk of harm as a result of conduct relating to a dangerous controlled drug

The panel also took into account the following mitigating feature:

- No evidence of actual harm caused to the patients

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of Miss Brown's dishonesty. 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 Miss Brown's dishonesty, and the public protection issues identified, an order that does not restrict Miss Brown'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 Miss Brown'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 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 Miss Brown's registration would be a sufficient and appropriate response. The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature and seriousness of the charges in this case. The panel was satisfied that due to the extent of Miss Brown's dishonesty, fabrication of patient details and misappropriation of Fentanyl, the misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Brown's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The 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 Miss Brown's repeated actions and dishonesty is fundamentally incompatible with Miss Brown remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction because there was evidence of harmful, deep-seated attitudinal problems, this was a course of action rather than a single incident and the panel was not satisfied that Miss Brown had insight and did pose a significant risk of repeating behaviour.

Finally, in looking at 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?*

Miss Brown's repeated actions and dishonesty were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Brown's actions were extremely serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Assessing 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 matters it identified, in particular the effect of Miss Brown's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themself, the panel concluded that nothing short of this would be sufficient in this case.

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

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC stating that if a finding is made that Miss Brown's fitness to practise is impaired on public protection grounds and a restrictive sanction imposed, an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

The NMC further submitted that if a finding is made that Miss Brown's fitness to practise is impaired on public interest grounds and that her conduct was fundamentally incompatible with continued registration, an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel determined that in view of its findings and reasons overall, only an interim suspension order would be consistent with its determination, and it would also be proportionate.

The panel therefore imposed an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

This will be confirmed to Miss Brown in writing.

That concludes this determination.