Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 9 July 2024 – Friday, 19 July 2024

Virtual Hearing

Name of Registrant:	**Alison Jayne Capel**
NMC PIN	06B0468E
Part(s) of the register:	RNA Registered Nurse Sub Part 1 – Adult – Level 1 May 2006
Relevant Location:	Sheffield
Type of case:	Misconduct
Panel members:	Ashwinder Gill (Chair, Lay member) Esther Craddock (Registrant member) David Boyd (Lay member)
Legal Assessor:	Andrew Young (9 July 2024 – 17 July 2024) Angus Macpherson (18 July 2024 and 19 July 2024)
Hearings Coordinator:	Hamizah Sukiman
Nursing and Midwifery Council:	Represented by Arran Dowling Hussey, Case Presenter
Mrs Capel:	Not present and unrepresented
Facts proved by admission:	Charges 5, 6, 8a, 8b and 8c
Facts proved:	Charges 1a, 1b, 1c, 2a, 2b, 2c, 3, 9, 10 and 11
Facts not proved:	Charges 4a, 4b, 4c, 7a and 7b
Fitness to practise:	**Impaired**

Sanction:	**Striking-off Order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Capel was not in attendance and that the Notice of Hearing letter had been sent to Mrs Capel's registered email address by secure email on 29 May 2024.

Mr Dowling Hussey, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). He referred the panel to an email correspondence from Mrs Capel, dated 27 June 2024, which confirmed that she was aware of this hearing, and that she did not wish to attend.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Capel's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Capel

The panel next considered whether it should proceed in the absence of Mrs Capel. It had regard to Rule 21 and heard the submissions of Mr Dowling Hussey who invited the panel to proceed in the absence of Mrs Capel. He submitted that Mrs Capel is aware of today's hearing and has voluntarily absented herself. He referred the panel to the email sent by Mrs Capel to the NMC, dated 27 June 2024, which stated:

'Thank you for all your hard work.
I am aware of the upcoming hearing but, as I have previously stated, I will not be attending.'

He submitted that there is no unfairness to Mrs Capel by proceeding in her absence. He further submitted that there is no realistic suggestion that Mrs Capel's attendance can be secured at a later date by adjourning the hearing today, as she has indicated she does not wish to attend.

The panel accepted the advice of the legal assessor, who drew the panel's attention to the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162. The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Mrs Capel. In reaching this decision, the panel has considered the submissions of Mr Dowling Hussey, the email correspondence from Mrs Capel, and the advice of the legal assessor. It had regard to the factors set out in the decision of *Adeogba* and to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Capel, through her email correspondence dated 27 June 2024, has indicated that she has received the Notice of Hearing and confirmed she would not be attending the hearing;
- Mrs Capel, in the completed Case Management Form dated 17 March 2024, has indicated that she does not wish to continue nursing or to attend the hearing;
- No application for an adjournment has been made by Mrs Capel;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Five witnesses are due to attend to give live evidence in this hearing;

- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the patients who need their professional services;
- The charges relate to events that occurred, at the earliest, in 2016;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

The panel acknowledged that there would be some disadvantage to Mrs Capel in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Mrs Capel on her registered email address, the panel accepted that she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Capel's decision to absent herself from the hearing, waive her rights to attend, be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge (as amended)

That you, a registered nurse:

1) On various dates in or around 2016, bullied a colleague, namely Colleague A, by:
    a) implying that said colleague was involved in prostitution.
    b) intentionally walking into said colleague.
    c) routinely speaking disrespectfully to said colleague.

2) In or about April 2021:
    a) checked, dispensed and administered medication relating to Patient E which required a second checker to be present on your own.
    b) put pressure on a junior colleague, namely Colleague B, to sign as a second checker for the medication referred to at charge 2a, when you knew they had not witnessed the preparation or administration of said medication.
    c) allowed a junior colleague, namely Colleague B, to inaccurately record that they had second checked medication you had prepared and administered when you knew they had not second checked it.

3) Your actions at charge 2c above were dishonest in that you knew the medication you had prepared and administered had not been second checked and you intended any subsequent reader to believe it had been.

4) On or around 01 June 2021, having been alerted to Patient F's deteriorating condition by a junior colleague, failed to:
    a) provide a plan for care and next steps.
    b) assist with Patient F's observations and/or arterial blood gas.
    c) escalate Patient F's condition to a doctor when it would have been clinically appropriate to do so.

5) On 09 June 2021, attempted to administer Gabapentin to Patient B when Pregabalin was prescribed.

6) On 28 June 2021, administered Adcal D3 to Patient A when Adcal 1500mg Calcium Carbonate was prescribed.

7) On 30 June 2021:
    a) administered Tobramycin to Patient D at a time other than when it had been prescribed.
    b) failed to record that you had administered Tobramycin to Patient D.

8) On 10 and/or 11 July 2021, administered a DNAse nebuliser to Patient C:
    a) without a valid prescription.
    b) from a different patient's supply.

    And

    c) failed to sign or otherwise make a note to record that you had administered a DNAse nebuliser to Patient C.

9) Following medical patients being admitted to the Cystic Fibrosis Unit, gave Cystic Fibrosis patients and/or allowed Cystic Fibrosis patients to be given preferential treatment in comparison with medical patients.

10) On an unknown date, told junior staff members '*do not forget who gets the datix forms'* or said words to that effect.

11) Your conduct at charge 10 above was intended to remind junior colleagues that you would know if they submitted Datix forms about errors you had made and intimidate them into not doing so.

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

Decision and reasons on application to amend the charge

The panel heard legal advice on its powers to amend charges, of its own accord, in accordance with Rule 28 of the Rules. Mr Dowling Hussey submitted that the NMC did not consider any amendments to the charges to be necessary.

The panel considered the proposed amendment to include identifying colleagues and patients in Charges 1 and 2, which are as follows:

"That you, a registered nurse:

1) On various dates in or around 2016, bullied a colleague, **namely Colleague A**, by:
    a) ...
    b) …
    c) …

2) On 29 April 2021:
    a) checked, dispensed and administered medication **relating to Patient E** which required a second checker to be present on your own.
    b) put pressure on a junior colleague**, namely Colleague B,** to sign as a second checker for the medication referred to at charge 2a, when you knew they had not witnessed the preparation or administration of said medication.
    c) allowed a junior colleague, **namely Colleague B**, to inaccurately record that they had second checked medication you had prepared and administered when you knew they had not second checked it.

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

The panel accepted the advice of the legal assessor.

The panel was satisfied that there would be no prejudice to Mrs Capel and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to make the amendment of its own accord, to provide clarity as to the persons concerned in the respective charges.

Background

The charges arose whilst Mrs Capel was employed by Sheffield Teaching Hospitals NHS Foundation Trust ('the Trust') as a registered nurse at the Cystic Fibrosis Unit ('CFU'). She commenced her employment with the Trust on 2 May 2006. The charges broadly concern Mrs Capel's medication management, record keeping, as well as her behaviour towards patients and colleagues.

On 15 March 2021, Mrs Capel was promoted to a Band 6 Sister role at the CFU, having worked at the CFU for approximately eight years. As a result of concerns being raised regarding her clinical practice, an initial, informal 'fact-finding' exercise was undertaken by the Matron. The provisional findings were shared verbally with Mrs Capel.

On 22 July 2021, Mrs Capel was redeployed to another ward as an alternative to suspension. She was advised, at this stage, that she was under supervision, and she was not to undertake any element of medication management on her own. [PRIVATE].

In March 2022, Mrs Capel's then-line manager requested that a more 'in-depth' investigation should be undertaken regarding the incidents identified in the informal 'fact-finding' exercise. At this stage, Mrs Capel had returned to work. It was alleged, at this stage, Mrs Capel failed to improve despite supportive intervention. Serious allegations involving her medication errors reported via the Datix system, her practice regarding medication administration and management as well as her attitude and professional behaviours were raised against Mrs Capel.

Decision and reasons on application to hear telephone evidence from Witness 3

On the third day of proceedings, the panel was informed by the Hearings Coordinator that Witness 3 was experiencing technical issues with accessing MS Teams through her device. The panel was told that the Hearings Coordinator has been on a telephone call with Witness 3 prior to the public session starting at 09:15 to resolve these issues, and the

Hearings Coordinator was unable to confirm whether the technical issues would be resolved within a reasonable time.

Mr Dowling Hussey submitted that, in light of the technical issues, the NMC is content to proceed with Witness 3 giving live evidence via telephone. He further submitted that the panel had met and seen Witness 3 via MS Teams video link the previous afternoon, and it may be able to satisfy itself that Witness 3 is in the same room, she is likely on her own and would just be on her telephone rather than an iPad or laptop.

The panel heard and accepted the advice of the legal assessor, who reminded the panel to bear in mind fairness and the interest of justice of all parties, including Mrs Capel, who is not in attendance and not represented at this hearing. He confirmed that it was within the Rules for the panel to hear Witness 3's live evidence via the telephone.

The panel took into account that Witness 3 has informed the panel that she would be unavailable from 13:00 on Day 3, and she had no further availability within the remaining hearing days to give her live evidence. The panel considered the efforts made by the Hearings Coordinator to help Witness 3 join the MS Teams link, and the technical difficulties Witness 3 was facing. The panel also considered Witness 3's desire to commence with her evidence, even if it must be done via telephone. The panel accepted that, if Witness 3 gave evidence via a telephone call, hearing participants would not be able to see Witness 3 but would be able to hear her. The panel noted that, alongside her live evidence, the panel had sight of her witness statement, as well as the local statement she made at the time of the incident in 2016.

In these circumstances, the panel came to the view that it would be fair to allow Witness 3 to give live evidence over the telephone.

Decision and reasons on application to amend Charge 2

On the third day of the hearing, the panel heard evidence from Witness 4 which suggested an inconsistency between paragraph 2 of his witness statement, which stated he began his role at the CFU on 11 December 2021, and the incident outlined in Charge 2, which allegedly occurred on 29 April 2021, as set out in paragraph 7 of his witness statement. In his oral evidence, Witness 4 also expressed uncertainty over the exact date of the incident.

To clarify this inconsistency, the panel sought additional information from Witness 4 after he finished his live evidence, namely asking him, if possible, to provide the following by 12:00 on Day 5:

- Any documentation as to correctness or otherwise of his start date at CFU, as stated in Paragraph 2 of Witness 4's witness statement, namely 11 December 2021; and
- Any documentation, for example emails or messages, to confirm the correctness or otherwise of the date of the incident involving Controlled Drugs book regarding Patient E, as stated in his witness statement, namely 29 April 2021.

This request was sent via email at 10:42 on Day 4. On Day 5, the panel was informed that the Hearings Coordinator had attempted to telephone Witness 4 but was sent straight to voicemail. The panel was also told that the Hearings Coordinator attempted to telephone Witness 4 at approximately 09:15 and 11:00 on Day 5 but Witness 4 did not answer on both occasions. As of 12:00 on Day 5, Witness 4 has not responded to the email sent or returned the calls.

The panel considered the legal advice on its powers to amend charges, of its own accord, in accordance with Rule 28 of the Rules in light of a lack of documentation which could clarify the inconsistency. Mr Dowling Hussey submitted that he has no instructions from

the NMC to amend the charge, but he suggested that a broader wording may help the panel in its decision making.

The panel considered the proposed amendment to the stem of Charge 2, which stated:

> "That you, a registered nurse:
>
> 1) ~~On~~ **In or about** ~~29~~ April 2021:
>
> a) …
>
> b) …
>
> c) …
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

The panel accepted the advice of the legal assessor, who drew the panel's attention to a relevant extract from the Criminal Law textbook Archbold '*Criminal Practice and Pleading*', at paragraphs 1-222 and 1-223. The panel accepted that, although the text referred to criminal proceedings, these principles were equally applicable to regulatory proceedings.

The panel was satisfied that there would be no prejudice to Mrs Capel and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to make the amendment of its own accord, to provide clarity and consistency with other evidence available before the panel.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Dowling Hussey that, according to the completed Case Management Form dated 17 March 2024, Mrs Capel has made full admissions to charges 5,6, 8a, 8b and 8c.

The panel therefore finds charges 5,6, 8a, 8b and 8c proved in their entirety, by way of Mrs Capel's admissions in the Case Management Form, signed and dated 17 March 2024.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case. The panel also considered submissions made by Mr Dowling Hussey and the information provided by Mrs Capel as outlined in the Case Management Form, dated 17 March 2024, as well as the Regulatory Concerns Response Form, dated 1 February 2023.

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

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

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

- Witness 1: Deputy Nurse Director at the Trust (at the time of the incident)
- Witness 2: Ward Manager of the CFU at the Trust (at the time of the incident)
- Witness 3: Housekeeper on the CFU (at the time of the incident)
- Witness 4: Band 5 Staff Nurse on the CFU (at the time of the incident)

- Witness 5: Trainee Nursing Associate on the CFU (at the time of the incident)

The panel heard and accepted the advice of the legal assessor, who reminded the panel of the burden of proof resting on the NMC and referred the panel to the NMC's Evidence Matrix. He drew the panel's attention to the cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and *Imani v General Dental Council* [2024] EWHC 132 (Admin) in relation to hearsay evidence. He reminded the panel that, with regard to the charges regarding failure to complete an act, the panel must satisfy itself that Mrs Capel was under either a legal or a professional duty to perform that act, or to perform it in the manner alleged, and that she was in breach of that duty. With regard to the dishonesty charge, he reminded the panel of the elements outlined within *Ivey v Genting Casinos* [2017] UKSC 67.

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

Charge 1(a)

"That you, a registered nurse:

1) On various dates in or around 2016, bullied a colleague, namely Colleague A, by:
    a) implying that said colleague was involved in prostitution."

This charge is found proved.

In reaching this decision, the panel considered the handwritten, contemporaneous statement written by Witness 3, who is identified as Colleague A in the charge, dated 8 July 2016. The panel considered that the handwritten statement stated:

> *"… on numerous occasions* [sic] *make comment about me working at the townhall step for money*"

The panel also considered the interview conducted by Witness 1 with Witness 3 on 4 May 2022. The panel determined that Witness 3's account at the interview is consistent with the initial handwritten statement made in 2016. The panel noted, from Witness 1's live evidence, that the particular "townhall" area in Sheffield is historically associated with prostitution, and this was corroborated by live evidence from Witness 3. Both Witness 1 and Witness 3 gave evidence that it would be clear to those living in Sheffield that a comment of this nature was a reference to prostitution.

The panel further determined that Witness 3's live evidence was also consistent with both her initial statement in 2016 and the account given in the interview with Witness 1 in 2022. Accordingly, the panel was satisfied that, on the balance of probabilities, Mrs Capel did make the comments as alleged, and that those comments did imply that Witness 3 was involved in prostitution.

With regard to bullying, the panel had regard to the NMC Guidance on Seriousness, with a particular focus on the sub-heading '*Bullying, harassment (including sexual harassment) and victimisation'* (FTP-3). The guidance states:

> *'Bullying can be described as unwanted behaviour from a person or a group of people that is either offensive, intimidating, malicious or insulting. It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone. It can be a regular pattern of behaviour or a one-off incident and can happen face-to-face, on social media or over emails or telephone calls. Usually bullying would be a pattern of behaviour, but an example of when it could be a one off incident could be if a member of the public felt that they had been bullied into agreeing to a do not resuscitate decision by a healthcare professional.'*

The panel determined that, as Witness 3 was a housekeeper and Mrs Capel was a senior nurse, Mrs Capel's behaviour was intended to humiliate a junior colleague. The panel was

satisfied, based on both documentary evidence and live evidence from Witness 3, that this behaviour was repeated and specifically targeted towards Witness 3. The panel heard from Witness 3 that, if Mrs Capel's behaviour had not stopped, she would have left her job. The panel determined that Witness 3 was clear and consistent that Mrs Capel's actions constituted bullying.

Witness 2 told the panel that this behaviour persisted beyond 2016. The panel did not rely on this evidence to prove this charge as it does not concern the dates particularised in the charge but recorded it as being potentially relevant to the later stages of this hearing.

Witness 1 confirmed that the concerns were raised with Mrs Capel at the time regarding her behaviour. This was documented on Mrs Capel's personnel file, dated 11 July 2016.

The panel also took into account the response provided by Mrs Capel at the time, where she denied bullying Witness 3. The panel considered Mrs Capel's interview on 2 September 2022, where she stated:

> *"… Also the things that [Witness 3] said about 'working on the townhall steps'. I didn't know her very well at the time, and she was going on holiday to somewhere exotic, and I jokingly said this. The SSR did tell me I had upset her and that she is really sensitive. I cannot think how I have made her life a misery. We have been on ward holidays and nights out. I have had birthday cards from her. I am at a loss."*

The panel also considered that, when asked in the interview whether this was her "*sense of humour*" or "*banter*", Mrs Capel confirmed that this was her sense of humour, which "*hasn't gone down very well*".

The panel determined that Mrs Capel's interview made clear that the comments implying Witness 3 was involved in prostitution were made. It further determined that, given the impact of those comments on Witness 3, the comments were unwanted and humiliated her and consequently influenced her decision on whether to stay in her role if the

behaviour persisted from Mrs Capel. The panel was satisfied that, as the matter was on Mrs Capel's personnel file, Mrs Capel should have been aware of the impact of her behaviour on Witness 3. The panel was satisfied that this constituted bullying, pursuant to the NMC guidance. Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 1(b)

"That you, a registered nurse:

1) On various dates in or around 2016, bullied a colleague, namely Colleague A, by:

b) intentionally walking into said colleague."

This charge is found proved.

In reaching this decision, the panel considered Witness 3's handwritten account of Mrs Capel's behaviour, dated 8 July 2016, which stated:

"*Recently barged into me on the ward, saying get out of my way*."

The panel also considered Witness 3's live evidence, where she detailed that the incident occurred on a long corridor, and she and Mrs Capel were walking in opposite directions. When asked on whether Mrs Capel could have accidentally bumped into Witness 3, the panel heard that Witness 3 was certain it was not an accident, and her recollection of this incident being deliberate was consistent with both her handwritten account as well as her witness statement to the NMC. The panel noted Witness 3's witness statement, which stated:

"*Mrs Capel displayed this type of behaviour towards me on most shifts. On one occasion Mrs Capel's behaviour escalated and they barged into me when walking*

through the CFU. Mrs Capel was a fairly large lady and I am only eight stone. Mrs Capel did this on purpose and said 'oops sorry, move out of the way'…"

The panel noted that the two statements, whilst slightly different in its wording, are broadly consistent.

The panel took into account that Mrs Capel was not specifically asked about this incident in any of the investigatory interviews. However, the panel noted that Mrs Capel has denied this charge in the completed Case Management Form.

The panel was satisfied, based on both documentary and live evidence from Witness 3, that Mrs Capel did not accidentally bump into Witness 3, and that it was deliberate. The panel noted that the stem of this charge referred to *"various dates".* However, the panel was satisfied that this sub-charge is proved on the basis of the evidence of a single incident, as it was of the view that the stem of the charge relates to all three sub-charges, taken as a whole.

The panel also considered the NMC Guidance on bullying, as outlined in its decision on Charge 1a. The panel was satisfied, based on the information before it, that Mrs Capel barged into Witness 3 deliberately as part of a wider bullying pattern against her. Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 1(c)

"That you, a registered nurse:

1) On various dates in or around 2016, bullied a colleague, namely Colleague A, by:
    c) routinely speaking disrespectfully to said colleague."

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement as well as her live evidence. Witness 3 stated, in her witness statement, that:

> *"Mrs Capel liked to embarrass me and belittle me in front of others. This made me feel bad and embarrassed."*

The panel also heard from Witness 3 that Mrs Capel spoke to her in a disrespectful tone, and she described Mrs Capel as being "*rude and nasty*" to her. Witness 3 told the panel that, when she asked Mrs Capel about the allergen information for the patients on the CFU, Mrs Capel was abrupt in her response. She also told the panel that she avoided speaking to Mrs Capel, as she never received a "*straight response*" from Mrs Capel. She told the panel that Mrs Capel's behaviour made her unhappy, and that she did not want to stay in the ward.

The panel also noted the observations made by Witness 2, which were outlined in her witness statement. The panel accepted that Witness 2 did not start working on the CFU until a date after the dates relevant to this charge, but the panel noted that Witness 2 asserted that Witness 3 was spoken to disrespectfully by Mrs Capel on a regular basis.

The panel also bore in mind its findings in Charge 1a and noted that the comments were of a disrespectful nature.

The panel noted that Mrs Capel did not make a specific response to this allegation, and it considered her general comment, made in the interview dated 2 September 2022, on her relationship with Witness 3, as well as her "*banter*" with Witness 3, as outlined in Charge 1a above.

The panel was satisfied, based on the documentary evidence as well as live evidence from Witness 3, that Mrs Capel was routinely speaking disrespectfully to Witness 3.

The panel took into account the NMC Guidance on bullying, as outlined in its decision on Charge 1a. The panel was satisfied, based on the information before it, that Mrs Capel routinely spoke to Witness 3 disrespectfully, and this amounted to bullying. Accordingly, the panel found this charge proved, on the balance of probabilities.

Charge 2(a)

"That you, a registered nurse:

2) In or about April 2021:

a) checked, dispensed and administered medication relating to Patient E which required a second checker to be present on your own."

This charge is found proved.

In reaching this decision, the panel considered the Trust's policy on dispensing controlled drugs, the witness statement from Witness 4, who is identified as Colleague B in these charges, as well as live evidence from both Witnesses 4 and 1.

The panel had regard to Section 4.8.8 of the '*Administration of Controlled Drugs'* policy in the Trust's Medicine Code, which outlined the requirement for a second checker to be present when administering controlled drugs. The policy stated:

> *"Two practitioners must check the administration of schedule 2 CDs and Sativex. One practitioner will take the lead and administer the medicine, and the other act as a witness to the procedure. The witness, who may be a student nurse, must be present at all stages of the process from obtaining the medicine from the locked cupboard to administering the correct dose to the patient. The witness must independently check to confirm the identity of the CD, the strength, dose and expiry."*

The panel considered the live evidence from Witness 1, who confirmed the Trust's policy and the requirement to have a second checker present.

The panel also considered both the documentary and live evidence from Witness 4. The panel acknowledged that Witness 4 was unable to clearly outline the exact dates in which he started at the CFU or the date of the incident. However, in response to panel questions, Witness 4 confirmed that the incident occurred at least three to four months after he commenced his employment at the CFU. He also told the panel that his interview with Witness 1 occurred approximately 12 months after the incident. The panel noted that the record of this interview is dated 26 April 2022. Based on this information, the panel was satisfied that Witness 4 commenced his employment at the CFU in or about December 2020 (not 2021 as stated in paragraph 2 his witness statement), and that this incident took place in or about April 2021.

The panel determined Witness 4 gave a clear and consistent account of the details of the incident. The panel considered the written account he provided as part of the investigation. The panel noted that this statement is undated, but it concluded that the contents of the statement are consistent with other documentary evidence and his live evidence. Witness 4 told the panel, in his live evidence, that although he was present in the room when Mrs Capel was counting drugs, she was counting them *'by herself'* and he therefore did not have an opportunity to see the medication. He went on to state that Mrs Capel left the room for a few minutes and when she returned, she asked him to sign as the second checker for the controlled drugs, although he had not seen the drugs being administered to the patient. Witness 4 told the panel that he initially declined to do this, but he felt pressurised to do so by Mrs Capel as she was persistent and said, *'I gave it, just sign it'.* He further stated that when he had refused to sign, Mrs Capel's voice was '*rising'*, she was not happy and that he felt he did not show *'courage'* as she was in a manager's position. Witness 4, therefore, eventually did sign as second checker. Following the incident, Witness 4 raised concerns about what had happened.

The panel noted that Witness 1, in her investigation, corroborated Witness 4's account through the evidence of another witness. This witness was not called by the NMC, and their account is not available before the panel. Accordingly, the panel did not take this into account in its decision-making.

The panel also considered the interview conducted with Mrs Capel by the Matron on the ward, who has not been called as an NMC witness at this hearing. The panel accepted that this interview transcript is undated and unsigned, but it noted that it is exhibited as part of Witness 2's Investigation Report, which was dated 11 February 2022. Accordingly, the panel was satisfied that this interview took place prior to this date. In this interview, the panel considered that Mrs Capel was aware of the Trust's policy on the administration of controlled drugs, and she was able to tell the Matron the requirement for two practitioners to be present when dispensing and administering controlled drugs.

The panel also considered Mrs Capel's response in the investigation, where she told Witness 1 that she "*genuinely cannot remember*" the incident.

Based on the documentary evidence before it as well as the live evidence from Witness 4 as to the circumstances of the incident and Witness 1, in relation to the Trust's controlled drugs policy, the panel was satisfied that Mrs Capel checked, dispensed and administered medication relating to Patient E which required a second checker on her own. Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 2(b)

"That you, a registered nurse:

2) In or about April 2021:

b) put pressure on a junior colleague, namely Colleague B, to sign as a second checker for the medication referred to at charge 2a, when you knew they had not witnessed the preparation or administration of said medication."

This charge is found proved.

In reaching this decision, the panel considered its decision in Charge 2a. The panel had regard to the aforementioned documentation, namely the undated local statement from Witness 4, the Trust's policy on the administration of controlled drugs, the interview he had with Witness 1, dated 26 April 2022 and signed on 26 August 2022, as well as the live evidence from Witness 4. The panel heard from Witness 4 that there are two parts to the administration of controlled drugs, namely a Controlled Drugs logbook as well as an Electronic Prescribing and Medicines Administration ('ePMA') system. Witness 4 told the panel that she asked him to sign the logbook as the second checker, and he initially declined to do so. He explained to the panel how Mrs Capel raised her voice, and he was repeatedly pressurised by Mrs Capel to sign as the second checker. He informed the panel that he escalated this situation, and he had a meeting with the Ward Manager a few days later.

The panel determined that his account in his documentary evidence and his live evidence is consistent. The panel considered that Mrs Capel was a more senior nurse and a manager, and she knew that Witness 4 did not want to sign as second checker as he did not witness the controlled drugs either being counted or being administered. The panel also determined that, despite this, Mrs Capel raised her voice and pressurised Witness 4 to sign as second checker.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 2(c)

"That you, a registered nurse:

2) In or about April 2021:

c) allowed a junior colleague, namely Colleague B, to inaccurately record that they had second checked medication you had prepared and administered when you knew they had not second checked it."

This charge is found proved.

In reaching this decision, the panel took into account its decision and reasons in Charges 2a and 2b. The panel determined that, based on the documentary evidence and live evidence provided by Witness 4, Mrs Capel was aware that Witness 4 had not witnessed her counting and administering the controlled drugs, but pressurised him to sign as second checker, nonetheless. The panel was satisfied, based on all the evidence as well as its decision in Charges 2a and 2b, that this charge is found proved on the balance of probabilities.

Charge 3

"That you, a registered nurse:

3) Your actions at charge 2c above were dishonest in that you knew the medication you had prepared and administered had not been second checked and you intended any subsequent reader to believe it had been."

This charge is found proved.

In reaching this decision, the panel noted its decision in Charge 2. The panel considered the live evidence from Witness 1, who told the panel of the importance of having a second checker for controlled drugs, given its tight regulation. Witness 1 told the panel that the records associated with controlled drugs are subject to a regular audit. The panel also considered Witness 1's witness statement on controlled drugs, which stated:

"Controlled drugs tend to be very strong painkillers, like morphine, and therefore they can kill or cause brain injuries if they are not administered correctly. Additionally, they

are normally drugs of abuse, which if fallen into the wrong hands can represent a wider danger."

The panel noted Mrs Capel denied the allegation.

The panel considered the legal advice on *Ivey*. The panel concluded that Mrs Capel knew Witness 4 had not witnessed her preparing or administering the controlled drugs because he was not present by her side when she did so and as he repeatedly refused to sign the logbook. The panel determined that, despite this, she had repeatedly pressurised him to do so to create the false impression that the controlled drugs were properly administered in accordance with the Trust's policy. The panel determined that any ordinary, decent person would find Mrs Capel's actions, in this respect, to be dishonest. Accordingly, the panel found this charge proved.

Charge 4(a)

"That you, a registered nurse:

4) On or around 01 June 2021, having been alerted to Patient F's deteriorating condition by a junior colleague, failed to:

a) provide a plan for care and next steps."

This charge is found NOT proved.

In reaching this decision, the panel took into account the legal advice received regarding an allegation of a failure to complete a task, which required Mrs Capel to be under a duty to act under the circumstances. The panel bore this in mind throughout its decision-making for the entirety of Charge 4.

The panel considered the Trust's policy, '*Management of the Deteriorating Patient: Policy and Procedures'*, as well as the documentary and live evidence from Witness 5 and

Witness 2. The panel noted the Trust's policy on the responsibilities of nursing staff when a patient deteriorates, which stated:

> *"Registered Nurses are responsible for performing observations, recognising patient deterioration and escalating to the medical team."*

The panel also considered the Trust's policy on the frequency of observations of a deteriorating patient, as well as the policy on the National Early Warning Score ('NEWS2'), which stated:

> "*Observations should be started at the time of the patient's initial assessment. In addition, there should be a clear written plan that specifies how frequently the observations should be repeated, taking into account the patient's diagnosis, presence of co-morbidities and treatment plan."*

The panel considered Witness 5's witness statement and oral evidence, which outlined Patient F's condition as well as the actions both her and Mrs Capel took in the period of Patient F's deterioration. Witness 5 stated that she initially raised concerns with Mrs Capel about Patient F's deterioration approximately between 07:35 and 08:00. Witness 5 stated that she, Witness 5, took the initial set of observations and that Mrs Capel had entered the room with a blood pressure machine. Witness 5 confirmed that the NEWS2 score would be automatically generated from the observations taken and would appear on the e-Whiteboard. Witness 5 also stated that the NEWS2 score tells you the next actions to take and that on this occasion it indicated that the patient should be escalated to at doctor. Witness 5 confirmed that Mrs Capel did carry out a second set of observations and checked *"Patient F's blood pressure, oxygen levels and temperature."*

Witness 5 told that panel that Patient F's deterioration spanned a time period between approximately 07:30 to 12:00 and that doctor's first attended to see Patient F approximately between 09:45 and10:00 and subsequently a consultant attended approximately mid-morning.

Witness 5 further confirmed that:

- She did not know whether Mrs Capel had spoken with doctors about Patient F (stating that there were doctors based on CFU);
- She was not with Patient F for the entire duration as she was attending to other duties;
- She did not know whether Patient F's care plan had been updated by Mrs Capel;
- She did not know if Mrs Capel had gone to prepare medication for Patient F, and
- Mrs Capel would have been able to monitor Patient F's scores from the nurses' station.

Witness 5 in her witness statement stated that Mrs Capel had *"disappeared and not provided direction"*, however in response to panel questions confirmed that this was *"more of an assumption that she left me to my own devices"*.

The panel noted Witness 2's witness statement, which stated that:

> *"When [Witness 5] asked Mrs Capel for help, Mrs Capel said 'No, you get on with it'. I heard this directly… Mrs Capel just sat at the nurses' station and did not help.*"

This account was put to Witness 5, who could not recall that comment being made to her. The panel noted that Witness 5, in her witness statement, indicated that she made Mrs Capel aware of Patient F's condition, but did not ask Mrs Capel for support. The panel, therefore, concluded that there was an inconsistency between the two accounts.

The panel also considered Mrs Capel's response, as outlined in her interview with Witness 1, dated 7 April 2022, where she said that she was alerted to Patient F being poorly by Witness 5, she "*left the area to fetch the IV Furosemide which had been prescribed*", and when she returned with the medication, Witness 2 was already with Patient F helping Witness 5. Mrs Capel also stated that, by this stage, Patient F was getting medical attention, and doctors were present. She also stated that she knows Patient F well and

that he "*doesn't like a fuss*". She said that she "*didn't go in the room as much due to the number of people there*".

The panel also considered Mrs Capel's interview, dated 2 September 2022, where she stated:

> "*I had spoken to various people about what needed to be done and been involved. I did go away to prepare IV Furosemide. I did let [Witness 5] take the lead as a learning opportunity…*"

The panel considered that the Trust's policy places a duty on a registered nurse, when a patient is deteriorating, to complete observations at certain, regular times. The panel noted that it has not been provided with Patient F's medical records, care plans or NEWS2 scores for this incident. Therefore, the panel could not establish what observations and other steps were required by the plan of care and what actions were recorded, if any, in these records.

Having considered the above, the panel was satisfied, based on the written and live evidence from Witness 5, that Mrs Capel did conduct observations on Patient F as witnessed by Witness 5.

Furthermore, the panel also considered the Trust's policy on appropriate escalation to the medical team, depending on the patient's NEWS2 score. The panel determined that the Trust required Mrs Capel to conduct regular observations and monitoring of Patient F, and to escalate Patient F to the medical team as appropriate. The panel was not satisfied on the evidence available, namely from Witness 5's live evidence and Mrs Capel's response, that Mrs Capel had failed to do so.

Whilst the panel acknowledged that both Witness 2 and Witness 5 believed that Mrs Capel could have provided more support to Witness 5 – who was in training at the time – the panel was not satisfied that this lack of support speaks to this charge. The panel

determined that the NMC had failed to discharge its burden of proof and therefore found this charge not proved.

Charge 4(b)

"That you, a registered nurse:

4) On or around 01 June 2021, having been alerted to Patient F's deteriorating condition by a junior colleague, failed to:

b) assist with Patient F's observations and/or arterial blood gas."

This charge is found NOT proved.

In reaching this decision, the panel took into account its decision in Charge 4a. The panel considered the live evidence and witness statements from both Witness 2 and 5. The panel acknowledged the aforementioned inconsistency between Witness 2 and 5 regarding whether Mrs Capel completed observations on Patient F. However, the panel determined that Witness 5 – who was concerned about Patient F and was involved in Patient F's care during the deterioration – confirmed to the panel that Mrs Capel did conduct an observation when asked to do so. Accordingly, the panel found the first element of this charge not proved.

On the second element of the charge, the panel heard evidence from Witnesses 1 and 5 that the arterial blood gas would have been carried out by doctors, rather than a registered nurse. As such, the panel was not satisfied that this was a duty imposed upon Mrs Capel. Accordingly, the panel found this element of the charge not proved.

The panel found this charge, as a whole, not proved on the balance of probabilities.

Charge 4(c)

"That you, a registered nurse:

4) On or around 01 June 2021, having been alerted to Patient F's deteriorating condition by a junior colleague, failed to:

c) escalate Patient F's condition to a doctor when it would have been clinically appropriate to do so."

This charge is found NOT proved.

In reaching this decision, the panel took into account its decision in Charges 4a and 4b above.

The panel noted that it has not been provided with Patient F's medical records which may assist with its decision-making. However, it considered Witness 5's evidence that doctors – and a consultant at a later stage – attended Patient F. The panel noted the aforementioned inconsistency between Witness 2 and Witness 5's account of the incident. The panel considered that Witness 5 was unable to confirm whether Mrs Capel had escalated Patient F to the doctors, as she was not with Patient F for the entirety of the duration.

The panel noted that Mrs Capel, in her interview with Witness 1, dated 7 April 2022 as well as her interview dated 2 September 2022 which stated that she told the doctors about Patient F.

Accordingly, the panel was not satisfied that this charge is proved.

Charge 7(a)

"That you, a registered nurse:

7) On 30 June 2021:

a) administered Tobramycin to Patient D at a time other than when it had been prescribed."

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, namely the Datix forms provided to the panel, as well as the evidence provided by Witness 1 and Witness 2.

The panel considered that it has not been provided with a copy of Patient D's medication records or care plans setting out the time at which Tobramycin was meant to have been administered. The panel accepted, based on the live evidence of Witness 1, that Tobramycin was meant to be administered once daily, but it was unable to determine the time.

The panel further considered that Witness 1, in her investigation, concluded that Mrs Capel administered Tobramycin to Patient D at a time other than when it had been prescribed based on the Datix forms. Further, Witness 2 referred to the same Datix form indicating this error. However, the Datix form before the panel – whilst with the correct date – does not relate to the administration of Tobramycin, but instead refers to another drug. Further, the panel determined that the Datix form has a reference of [PRIVATE], whilst Witness 2's investigation notes relating to this incident, dated 1 July 2021, has a reference number of [PRIVATE].

Furthermore, the panel also considered that the Datix form before it refers to the administration of Tazocin as opposed to Tobramycin, and it was unable to conclude whether this Datix form related to Patient D. When Witness 2 was asked regarding the Datix form, she was unable to clarify the position for the panel. She confirmed that there were multiple drug-related incidents at the time by staff on the ward.

The panel also considered Mrs Capel's responses, both during the course of the Trust's investigation and in the Case Management Form. The panel noted that, in the undated interview with the Matron, Mrs Capel was interviewed regarding intravenous ('IV')

administration, but the panel was unable to identify the drug or patient that this interview related to.

Furthermore, in Mrs Capel's interview dated 7 April 2022, Witness 1's notes indicated that there was an incident relating to Tobramycin, but no reference to the patient was made. Accordingly, the panel was unable to satisfy itself that this interview related to the incident outlined in the charge, given Witness 2's account that there were a number of drug-related incidents on the ward around this time. The panel considered the second interview held by Witness 1, dated 2 September 2022, where references to Tazocin were made. The panel concluded that, as it did not reference Patient D specifically , it was unable to conclude that this incident is the same one which relates to this charge.

The panel also noted that Mrs Capel denied this charge in the Case Management Form.

The panel concluded that, given the mismatched Datix reference numbers on the Datix forms given to it and Witness 2's investigation notes, it was unable to connect any the information provided by the Witness to the exact incident involving Patient D. The panel considered that both Witness 1 and 2 were not there at the time of the incident. Furthermore, the panel had not received a record of the ePMA chart indicating when Tobramycin was meant to have been administered to Patient D. Accordingly, as it was unable to determine when Tobramycin was meant to have been administered, it was not satisfied that Mrs Capel administered Tobramycin at a time other than when it has been prescribed. Consequently, the panel found this charge not proved.

Charge 7(b)

"That you, a registered nurse:

7) On 30 June 2021:

b) failed to record that you had administered Tobramycin to Patient D."

This charge is found NOT proved.

In reaching this decision, the panel took into account its decision in Charge 7a. The panel considered the aforementioned mismatched Datix reference numbers between Witness 2's investigation notes and the Datix forms available before the panel. The panel concluded that, in the absence of any documentation specifically relating to Patient D indicating that Mrs Capel had failed to record the administration of Tobramycin, this charge is found not proved on the balance of probabilities.

Charge 9

"That you, a registered nurse:

9) Following medical patients being admitted to the Cystic Fibrosis Unit, gave Cystic Fibrosis patients and/or allowed Cystic Fibrosis patients to be given preferential treatment in comparison with medical patients."

This charge is found proved.

In reaching this decision, the panel took into account the witness statements as well as live evidence from Witness 5, Witness 2 and Witness 1.

The panel considered Witness 5's witness statement, which stated:

"From the moment that I arrived on the CFU, medical patients were treated as inferior to CF patients by Mrs Capel and other members of staff […] Mrs Capel would differentiate between what food, equipment and facilities were for the CF patients, compared to the other patients. Mrs Capel often said 'that's for the CF patients'. For example, CF patients were allowed different, nicer food such as chocolate and crisps, chicken nuggets, pizzas, smoothies and ice cream sundaes […] Mrs Capel also did not allow the Medical Patients to use the glassware, pots and mugs that were for use on the CF unit…"

The panel heard from Witness 5 that Mrs Capel would not allow general medical patients to use glass crockery and made the general medical patients use plastic mugs instead. The panel determined that Witness 5's live evidence is consistent with her witness statement.

The panel considered Witness 5's whistleblowing meeting with the Matron, dated 30 July 2021, which alleged that Cystic Fibrosis patients were given preferential treatment. The panel has not had sight of the statement referred to in this meeting, but it was satisfied, based on the contents of the meeting, that Witness 5 stated that general medical patients were treated differently on the instruction of Mrs Capel.

The panel was satisfied that Witness 5's whistleblowing meeting, witness statement to the NMC and her live evidence were consistent.

The panel also considered Witness 2's witness statement, which stated:

"Mrs Capel was very judgmental of patients and they labelled patients differently."

In her live evidence, Witness 2 confirmed that Mrs Capel did not allow general medical patients to have duvets, limited glass crockery to Cystic Fibrosis patients and excluded general medical patients from having mocktails on Friday evenings. She told the panel that Mrs Capel told the patients that certain foods were limited to Cystic Fibrosis patients, and she put up posters on the CFU indicating that general medical patients should not be given things designated for Cystic Fibrosis patients, such as sweets or glass mugs. She confirmed there was no valid basis for this disparity, and, in her opinion, this was discriminatory.

The panel considered the email sent by Witness 2 to members of the CFU, dated 7 May 2021, detailing that all patients on the CFU must be treated equally, and that the money for the items on the CFU was funded by the Trust, rather than a Cystic Fibrosis charity. When asked in live evidence whether Mrs Capel's behaviour persisted following this email,

Witness 2 told the panel that Mrs Capel continued to treat Cystic Fibrosis patients differently despite the clarity of the email, insisting that she should not do so.

The panel also had regard to Witness 1's witness statement, which indicated that Mrs Capel believed that the families of Cystic Fibrosis patients had raised money for the Cystic Fibrosis patients to enjoy special treats. The panel considered the interview Mrs Capel had with Witness 1, dated 2 September 2022, where Mrs Capel denied putting the posters up, and stated that this "*was a culture way before [her] time*". The panel considered that Mrs Capel admitted to writing on the whiteboard in the kitchen regarding the use of crystal glasses, and that she believed that the funds for the additional sweets originated from the families of Cystic Fibrosis patients.

However, the panel determined that, whatever may have been the position earlier, Mrs Capel would have been aware of the funding now originated from the Trust following Witness 2's email on 7 May 2021. The panel was satisfied that the email was sufficiently clear to indicate where the funding had originated from, and the expectation to treat all patients on the CFU equally irrespective of whether they are Cystic Fibrosis patients or not. The panel accepted Witness 2's evidence that the preferential treatment persisted following this email.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 10

"That you, a registered nurse:

10) On an unknown date, told junior staff members 'do not forget who gets the datix forms' or said words to that effect."

This charge is found proved.

In reaching this decision, the panel considered Witness 2's witness statement as well as her live evidence. Witness 2 described the incident in her witness statement, which stated:

> *"I recall that Mrs Capel said to the staff members on the CFU 'do not forget who gets the datix forms' which was threatening. I heard Mrs Capel say this."*

This account was corroborated by Witness 2's live evidence. Witness 2 told the panel that she overheard Mrs Capel saying this to approximately four members of staff in a staff room. Witness 2 explained that she was physically close to Mrs Capel as she said this remark, and she confirmed that she directly heard Mrs Capel make this remark to junior members of staff.

The panel also considered Witness 2's interview, dated 19 August 2021, in which Witness 2 stated:

> *"AC was angrier about the datix rather than the incident. AC made it very clear to staff that she receives all the datixes which felt like a warning to staff not to datix her."*

The panel had regard to Witness 2's second interview, dated 19 April 2022, which stated:

> *"She was quite angry about the Datixes. Also, she as a Band 6 could see who had completed the Datix and afterwards she would be rude and off hand with the people completing the Datix."*

The panel determined that the account outlined in both pieces of documentary evidence remain consistent with the witness statement and live evidence provided by Witness 2.

The panel considered that this charge was not a concern that was put directly to Mrs Capel in the Trust's investigation process or in the Regulatory Concerns Response Form

as sent by the NMC. However, the panel noted that Mrs Capel has denied the charge in the Case Management Form but has not provided any further information.

Based on the documentary evidence as well as live evidence from Witness 2, the panel found this charge proved on the balance of probabilities.

Charge 11

"That you, a registered nurse:

11) Your conduct at charge 10 above was intended to remind junior colleagues that you would know if they submitted Datix forms about errors you had made and intimidate them into not doing so."

This charge is found proved.

In reaching this decision, the panel took into account its decision in Charge 10, as well as the witness statement and live evidence from Witness 2. The panel considered that Witness 2 described the manner in which Mrs Capel said the words in Charge 10 as "*threatening*", and that it "*made other staff members frightened to complete datix forms about Mrs Capel's errors*".

The panel also considered that, in live evidence, Witness 2 told the panel that there were junior members of staff in the room when she made the remark, and that Mrs Capel was being "*abrupt and confrontational*". She further told the panel that following the remark, staff told her that they were frightened to complete the Datix forms despite them verbally reporting to Witness 2 that incidents were still happening. Witness 2 confirmed that fewer Datix forms were completed, including a period where no Datix forms were being completed, following Mrs Capel's remarks. The panel was satisfied that Mrs Capel said the remarks in a threatening way with the intention of intimidating junior colleagues into not submitting Datix forms about errors Mrs Capel has made. The panel was satisfied that

the account provided in both Witness 2's witness statement and live evidence was consistent.

Accordingly, the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Capel'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, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct and impairment

Mr Dowling Hussey invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to each of the charges either admitted or found proved in turn.

With regard to Charge 1, Mr Dowling Hussey submitted that Mrs Capel's behaviour was prolonged and repetitive, intended to humiliate a more junior colleague, namely Witness 3. He further submitted that, alongside the verbal remarks, the panel has found that Mrs Capel has also physically intimidated Witness 3. He reminded the panel that the legal assessor will outline the legal test on misconduct and impairment for the panel's decision-making, and he submitted that Mrs Capel's actions as found proved in Charge 1 amount to misconduct and indicates an impairment to her fitness to practise.

With regard to Charge 2, Mr Dowling Hussey submitted that the facts found proved related to the core duties of nursing, namely the proper administration of medication. He submitted that there has been a breach in this core duty, and Mrs Capel has placed her colleague, namely Witness 4, in an insidious position and pressurised him to facilitate this irregular approach to the administration of controlled drugs. He further submitted that, taking Charges 2 and 3 together, this is unequivocally a case of misconduct, and crosses the threshold of impairment.

With regard to Charges 5 and 6, Mr Dowling Hussey invited the panel to consider the nature of the medication which Mrs Capel attempted to prescribe in place of the actual medication which had been prescribed. He submitted that the lack of an adverse effect on the patient does not detract from the seriousness of Mrs Capel's conduct.

Mr Dowling Hussey, with regard to Charge 8, submitted that Mrs Capel demonstrated a disregard to her duty to her patients as well as her duty as a practitioner to have careful records on medication administration. He further submitted that Mrs Capel's pattern of behaviour indicated her attitude towards the Trust's processes on medication administration. He submitted that this amounted to misconduct, and that her fitness to practise is impaired.

Mr Dowling Hussey submitted that treating Cystic Fibrosis patients differently to other patients on the CFU is an afront to the responsibilities of a registered nurse pursuant to 'The Code: Professional standards of practice and behaviour for nurses and midwives

2015' ('the Code'). He submitted that this was not an isolated incident, but was an elongated, repetitive distinction between the patients within the CFU. He further submitted that Mrs Capel's action has caused distressed to the patients on the CFU, and that this amounted to misconduct. Consequently, he submitted that this also demonstrated impairment.

Mr Dowling Hussey submitted that, in relation to Charge 10, Mrs Capel's intimidating remarks had a "*knock-on effect*" to the volume of Datix forms submitted, and consequently, the operation of the CFU as a unit. He submitted that Charges 10 and 11, taken together, amounted to misconduct, and demonstrated impairment.

Mr Dowling Hussey referred the panel to both *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and the Code. He submitted that Mrs Capel's actions were repeated breaches of core areas of the Code, specifically on the treatment of patients and colleagues with respect, as well as her duty to administer medication in accordance with the appropriate policies.

With regard to impairment, Mr Dowling Hussey submitted that both the public protection and public interest grounds are engaged. He further submitted that the public confidence in the nursing profession, and the NMC as its regulator, would suffer if instances of Mrs Capel's behaviour – namely the breach of core nursing skills and values – were not addressed with appropriate vigour. He also submitted that Mrs Capel's behaviour was repetitive, and there is nothing before the panel to indicate that, if a similar situation arose, this behaviour would not be repeated. He submitted that, whilst Mrs Capel does not wish to return to nursing, no evidence of her reflection or insight is available before the panel today.

He submitted that Mrs Capel's negative, harmful attitude towards both patients and her colleagues all amounted to misconduct and indicate impairment.

With regard to remediation, Mr Dowling Hussey outlined that registrants who appear before a Fitness to Practise Committee are able to outline their future plans in nursing, and consequently, their plans for remediation. He submitted that, in this case, this panel has no evidence to indicate Mrs Capel's remediation or future plans, save for her desire to no longer be in nursing practice. In response to panel questions on Mrs Capel's current position, Mr Dowling Hussey confirmed that meaningful contact with Mrs Capel has been limited, and she has taken no part in these proceedings. He informed the panel that the last update received from Mrs Capel indicated that she was not in employment presently and is seeking to work as a carer.

The panel accepted the advice of the legal assessor on both misconduct and impairment which included reference to a number of relevant judgments. These included: *Schodlok v GMC* [2015] EWCA Civ 789, *Ahmedsowida v General Medical Council [*2021] EWHC 3466 (Admin) *Cohen v GMC* [2008] EWHC 581, and the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (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 as well as the NMC Guidance on Misconduct (FTP-2a). In coming to its decision, the panel had regard to the case of *Roylance* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

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

To achieve this, you must:

1.1 treat people with kindness, respect and compassion.

1.3 avoid making assumptions and recognise diversity and individual choice.

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues.

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff.

8.4 work with colleagues to evaluate the quality of your work and that of the team.

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

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code.

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

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress.

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

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

The panel considered Charge 1 in its entirety. The panel was satisfied that paragraphs 1.1, 8.2, 8.3, 20.2, 20.5 and 20.8 of the Code outlined above are engaged.

On paragraph 1.1, the panel determined that Mrs Capel had failed to treat her colleague, Witness 3, with kindness, and instead demonstrated a pattern of both verbal bullying and, on one occasion, physical bullying. In this pattern of behaviour, the panel was satisfied

that Mrs Capel had failed to maintain effective communication with Witness 3. She did not keep Witness 3 informed of the necessary information by dismissing Witness 3 when she asked about patients' allergens, which would impact the care of patients on the CFU when asked, pursuant to paragraphs 8.2 and 8.3. The panel determined that all three sub-charges are stemmed in bullying, and that Witness 3 has been described by Witness 2 as very quiet and vulnerable, engaging paragraphs 20.2 and 20.5. The panel also determined, pursuant to paragraph 20.8, that Mrs Capel was a senior nurse, who was also the nurse in-charge, on a ward with student nurses. Her engagement amounted to a pattern of targeted bullying of another colleague, and this indicates a failure to act as a role model to the student nurses on the CFU.

The panel considered Witness 3's witness statement, which stated:

> *"Mrs Capel liked to embarrass me and belittle me in front of others. This made me feel bad and embarrassed…"*

The panel considered its findings on facts in Charge 1. It determined that this was a pattern of behaviour which persisted, despite Mrs Capel being addressed on the matter, as outlined in her personnel file. The panel was satisfied that this behaviour was designed to humiliate and intimidate Witness 3. The panel concluded that this is a serious departure from the standards expected of a nurse, and it amounts to serious misconduct.

The panel next considered Charges 2 and 3 together. It was satisfied that paragraphs 10.3, 18.2, 20.2, 20.3, 20.5 and 20.8 of the Code are engaged, as outlined above.

The panel considered its findings on facts in Charges 2 and 3 and concluded that Mrs Capel had failed to complete her records accurately. Mrs Capel chose to pressure Witness 4 into falsifying the records, identifying him as a second checker, when he had not acted in that capacity and consequently, she breached paragraph 10.3. Furthermore, given the charges related to controlled drugs, the panel was satisfied that paragraph 18.2 is engaged. Mrs Capel's dishonesty in falsifying the records allowed the panel to be satisfied

that paragraph 20.2 is engaged. The panel considered that Witness 4 was repeatedly pressurised into signing as second checker and would not have done so but for Mrs Capel pressuring him. The panel was satisfied that Mrs Capel had failed to recognise how her behaviour placed Witness 4 in a position of signing the controlled drugs logbook when he did not wish to do so, pursuant to paragraph 20.3 of the Code. The panel also considered how Witness 4 was a junior nurse at the time and had recently begun his employment at the CFU, whilst Mrs Capel was a senior nurse. The panel was satisfied that Mrs Capel took advantage of Witness 4's junior position, contrary to paragraph 20.5. Accordingly, the panel was satisfied that, as the nurse in charge, Mrs Capel was not acting as a role model and, to the contrary, demonstrated intimidating and dishonest behaviour towards a junior nurse.

The panel determined that Mrs Capel knew the Trust's policy and made a conscious decision to act outside this policy, by repeatedly pressuring Witness 4 into signing the logbook as the second checker. Mrs Capel was aware of the importance of adhering to policy on controlled drugs, and the impact of the misuse of controlled drugs on patients. The panel was satisfied that Mrs Capel used her authority to pressure Witness 4 into signing as a second checker, to create the impression on both the controlled drugs logbook and the ePMA that the controlled drugs were counted and administered in accordance with the Trust's policy. The panel considered that this dishonest falsifying of records, which is serious in itself, is heightened in its seriousness given the nature of controlled drugs. The panel concluded that Mrs Capel's acts in Charges 2 and 3 are a serious departure from the standards expected of a nurse, and amount to serious misconduct.

With regard to Charge 5, the panel had regard to the contextual information surrounding the charge provided by Witness 1. Witness 1 confirmed, in her witness statement, that it concerned an incident where Mrs Capel narrowly missed administering the incorrect medication to Patient B. Witness 1 further confirmed that reported this incident via a Datix form and reflected on the incident within the form. Witness 1 stated:

"Within the Datix, Mrs Capel reflected on this incident and talked about human error and distraction. Mrs Capel discussed the importance of checking that you are administering the correct drug…"

The panel noted that Witness 1 confirmed that no patient harm was caused, as Patient B identified that it was the incorrect medication before it was administered.

The panel considered that Mrs Capel did not deny this allegation at both the local investigations as well as in her Case Management Form. The panel also considered that, at the time, Mrs Capel apologised to Patient B. The panel noted that the reflection referred to by Witness 1 is not available before the panel, however the panel accepted that Mrs Capel did reflect on this incident. Whilst the panel noted Witness 1's evidence that the packaging would have been different between the two medications, and Mrs Capel should have recognised the difference, the panel considered that Mrs Capel admitted to being distracted and not attentive when she was preparing it.

The panel determined that Mrs Capel should have given more attention to the preparation of the two distinct medications, particularly given her seniority and relatively small size of the CFU. However, the panel accepted that Mrs Capel had completed a Datix form and reflected on the incident at the time, citing it to be a human error. Accordingly, the panel was satisfied that this amounts to misconduct, but not serious misconduct.

With regard to Charge 6, the panel considered the nature of the circumstances as described by Witness 1. Witness 1 indicated that there was a common issue amongst staff at the time relating to the two types of Adcal medications, as there was a shift from the CFU serving only Cystic Fibrosis patients to other general medical patients at the time. The panel noted that, when Mrs Capel was approached regarding her error, she had not appreciated that she had administered the wrong Adcal medication. At this stage, Mrs Capel had refused to do a reflection, but the panel noted that Mrs Capel admitted to this charge when it was put to her by the NMC. The panel took into account that Mrs Capel had requested training on Adcal, based on Witness 2's note of their conversation.

The panel accepted Witness 1's evidence that this incident, in isolation, is not very serious and she confirmed that there was no harm to Patient A.

The panel determined that this medication error, particularly in light of the one found proved by admission in Charge 5 above dating earlier in the same month, amounts to misconduct. However, the panel accepted the context of the changing needs of the ward at the time, and the similarities between the two types of Adcal medications. The panel also took into account that Mrs Capel appeared to be unaware of the differences between the medications until she was approached by Witness 2. The panel accepted that Patient A did not come to any harm with the administration of the wrong Adcal, and that this was a common error made by other staff at the time. Accordingly, the panel determined that this amounts to misconduct, but not serious misconduct.

The panel considered Charge 8 in its entirety. The panel considered Witness 1's witness statement which stated:

> *"I agree that withholding the drug would have been the wrong thing to do when Patient C needed it, however to give a drug that is not prescribed is wrong."*

The panel considered the context surrounding Charge 8. The panel accepted that Mrs Capel knew Patient C and knew that he was ordinarily prescribed the DNAse nebuliser. The panel also accepted that, Patient C had been admitted to the CFU for the weekend, and had not brought with him the DNAse nebuliser, which he self-administered at home and had previously been prescribed. In addition, the panel noted that, as it was the weekend, Mrs Capel had to request a prescription on the Hospital Out-of-Hours Board. The panel accepted that Mrs Capel had done so.

The panel accepted the difficult circumstances Mrs Capel was in, but it determined that options were available to Mrs Capel, which she chose not to pursue. The panel heard that Mrs Capel could have escalated her request on the Out-of-Hours Board, and the panel

accepted Witness 2's evidence that this would have allowed the matter to be dealt with within a reasonable timeframe. The panel took into account that this was not an emergency situation, and that the DNAse nebuliser for Patient C arrived the following Monday, two days after the request. Witness 1 and 2 also informed the panel that Mrs Capel should have flagged and escalated her initial request on the Out-of-Hours Board. Witness 2 also informed the panel that another patient's medication should never be given to a patient. The panel noted that there was no record made on Patient C's records that the DNAse nebuliser had been administered to him by Mrs Capel. The panel noted that Mrs Capel's actions, in relation to this incident, breached the Trust's medicines management policy. Accordingly, the panel determined that administering the DNAse nebuliser from another patient's supply, and the subsequent failure to record, amounts to serious misconduct.

With regard to Charge 9, the panel was satisfied that paragraphs 1.1, 1.3, 3.4, 20.1, 20.3 and 20.5 of the Code are engaged, as outlined above.

The panel concluded that, by openly and persistently providing Cystic Fibrosis patients with preferential treatment to the point of causing upset to both patients and colleagues, Mrs Capel has failed to treat people with kindness, respect and compassion, pursuant to paragraph 1.1. The panel was also satisfied that Mrs Capel had made presumptions about general medical patients, contrary to paragraph 1.3, by assuming that they are all unable to use glass crockery, instead of considering individual patients' frailty and ability. The panel was also satisfied that Mrs Capel has fallen far short of the standards expected of her as outlined in 3.4, as she was actively encouraging discriminatory attitudes against general medical patients. The panel also determined that Mrs Capel had failed to adhere to the values of the Code through her discriminatory practices and had actively encouraged other staff members to do the same, contrary to paragraphs 20.1 and 20.3 of the Code. The panel was satisfied that Mrs Capel, pursuant to paragraph 20.5, did take advantage of the vulnerability of other patients on the CFU and caused them upset, by deliberately creating a discriminatory environment determined by their diagnosis.

Accordingly, the panel concluded that Mrs Capel's action in Charge 9 amounted to serious misconduct and is a departure from the standards expected of her as a registered nurse.

The panel considered Charges 10 and 11 together. The panel was satisfied that paragraphs 8.4, 8.5, 19.1 and 20.8 of the Code, as outlined, are engaged.

The panel considered the purpose of completing the Datix forms, namely, to identify, record and reflect on incidents and near misses, which feeds into both individual and team training to ensure the mistakes do not occur again. The panel determined that, pursuant to paragraphs 8.4 and 8.5, Mrs Capel intimidating staff into not completing Datix forms on her errors prevents both herself and her colleagues from evaluating the quality of their work and consequently preventing the preservation of patient safety. The panel also determined that not having a record of near misses prevents Mrs Capel and her colleagues from taking action to reduce the likelihood of mistakes, as outlined in paragraph 19.1. The panel was also satisfied that, as a senior nurse who was intimidating junior members of staff into not completing Datix forms, Mrs Capel has failed to act as a role model to the staff, as required of her in paragraph 20.8 of the Code.

The panel also considered Witness 2's witness statement, which stated:

> *"… I arranged training on the importance of completing datix forms … Mrs Capel engaged in the training although there was no change in their attitude about completing datix forms."*

The panel bore in mind its findings on facts in Charges 10 and 11, and the impact of Mrs Capel's actions on the number of Datix forms received. The panel was satisfied that as a senior nurse who engaged in training, Mrs Capel was fully aware of the importance of completing Datix forms on both patient safety as well as individual and organisational learning but had chosen to prevent this to conceal her own errors which may otherwise have been reported via a Datix form.

Accordingly, the panel was satisfied that her actions in Charges 10 and 11 amount to serious misconduct.

The panel found that Mrs Capel's actions, taken together, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, 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/ fitness to practise is impaired in the sense that S/He:

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

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

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

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

With regard to the first limb, the panel determined that patients were put at risk of physical harm in Mrs Capel's care and were caused emotional harm as a result of Mrs Capel's misconduct. With regard to the risk of physical harm, the panel considered the evidence it

heard regarding the importance of adhering to the Trust's policy on controlled drugs given the nature of the drugs, as well as the importance of correctly documenting medication errors on Datix to allow for both individual and collective reflection on the medication errors. With regard to emotional harm, the panel determined that both the general medical patients and Mrs Capel's colleagues were upset by Mrs Capel's openly preferential treatment of Cystic Fibrosis patients.

With regard to the second limb, the panel was satisfied that Mrs Capel has brought the nursing profession into disrepute as the charges relating to both dishonesty and bullying are extremely serious. The panel also considered that Mrs Capel's actions indicated a pattern of behaviour, and, without adequate remediation, she is liable to bring the profession into disrepute in future.

On the third limb, the panel determined that Mrs Capel's misconduct had breached the fundamental tenets of the nursing profession as outlined in the Code. Mrs Capel, in her misconduct, had failed to treat people – both patients and colleagues – fairly and with dignity. Mrs Capel also failed to demonstrate adequate record-keeping and compliance with the Trust's medication policies on both controlled drugs and other medications. Furthermore, Mrs Capel has also been dishonest with her record keeping, with regard to Charge 2, and demonstrated intimidating behaviour to discourage colleagues from keeping an accurate record of her practice.

The panel also determined that the fourth limb is engaged, given the findings of Mrs Capel's dishonesty regarding the recording of the controlled drugs.

The panel considered whether Mrs Capel's misconduct is remediable. The panel was satisfied that, whilst her failures in medicines management may be remediated with some training, her pattern of behaviour surrounding the bullying and dishonesty are more difficult to remediate. The panel heard evidence from Witness 2, who indicated that after the incidents found proved in Charge 1 in 2016, Mrs Capel continued to target Witness 3 in 2021. The panel took into account Mrs Capel's use of her seniority to influence or

intimidate others, as well as treat others poorly. The panel considered her preferential treatment of Cystic Fibrosis patients, as outlined in Charge 9, despite being clearly told not to do so. The panel also considered Mrs Capel using her seniority to intimidate staff into not completing their Datix forms, and to pressure Witness 4 into signing as second checker when he repeatedly declined to do so. The panel concluded that this, paired with the elements of dishonesty, are difficult to remediate without full engagement on Mrs Capel's part.

The panel next determined whether the misconduct has been remediated, and it considered any insight and remediation Mrs Capel has shown since the incidents. The panel has not received any evidence from Mrs Capel indicating her insight, reflection into her actions or the strengthening of her practice. The panel noted that Mrs Capel wishes to remove herself from the nursing register and has indicated that she does not wish to return to nursing. The panel accepted that Mrs Capel's admitted Charges 5, 6 and 8 in its entirety, but noted that it lacked explanation as to how these charges arose, or any reflection on her actions in these charges. The panel concluded that her misconduct has not been remedied.

Accordingly, the panel is of the view that there is a high risk of repetition based on Mrs Capel's lack of remediation, insight, remorse or strengthening of her practice. The panel was not satisfied that Mrs Capel has demonstrated a period of safe practice since the incident. It concluded that the attitudinal nature of Mrs Capel's misconduct, without robust remediation, carries 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; 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 well-informed member of the public would be concerned if Mrs Capel was allowed to practise without restriction, in light of the panel's findings against her, particularly her dishonesty and pattern of behaviour towards others. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. Accordingly, the panel finds Mrs Capel's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC.

Submissions on sanction

Mr Dowling Hussey submitted that the panel has found seven of the nine charges amounted to serious misconduct. He further submitted that the following aggravating factors applied in this case:

- Mrs Capel, due to her seniority and the frequency of her being the nurse in charge, held a position of trust, which she abused;
- The bullying, intimidation and pressuring of colleagues indicated attitudinal issues and a lack of respect towards her colleagues, as it happened more than once and over a period of time; and

- Mrs Capel has provided no evidence of any insight, remediation or strengthening of her practice since the incidents.

Mr Dowling Hussey submitted that he could not identify any mitigating factors in this case, in light of Mrs Capel's absence, and her limited engagement with the NMC.

He invited the panel to consider the range of possible sanctions available to it. He submitted that taking no action, or imposing a caution order would not be proportionate in light of the panel's findings on misconduct and current impairment. He further submitted that a suspension order would not be an appropriate order; the panel has identified instances of grave misconduct, and such an order could damage the reputation of the nursing profession.

Mr Dowling Hussey submitted that the panel may find it difficult to impose a Conditions of Practice Order in light of Mrs Capel's desire to not return to nursing.

Mr Dowling Hussey submitted that the public interest in this case requires the panel to make a striking-off order. He submitted that the charges relate to the bullying and lack of respect for other nurses, staff and patients. He further submitted that the charges also concern the pressurising of a junior colleague to sign a controlled drugs logbook as a second checker when he was not acting as such. He submitted that the charges also related Mrs Capel's breach of a fundamental tenet of the nursing profession, namely the administration of medication.

He submitted that patients were placed at risk as a result of Mrs Capel's misconduct. Furthermore, he also submitted that Mrs Capel has caused upset and humiliation to patients and colleagues, in particular, Witness 3. He acknowledged that Mrs Capel did admit to some of her wrongdoing, but he submitted that Mrs Capel lacked adequate insight into her conduct.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

The panel noted that, in the Notice of Hearing, dated 29 May 2024, the NMC had advised Mrs Capel that it would seek the imposition of a striking-off order if it found Mrs Capel's fitness to practise currently impaired.

Having found Mrs Capel's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG, with reference to the NMC Guidance on Dishonesty (SAN-2) and Seriousness (FTP-3b). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mrs Capel was an experienced, senior nurse, and abused her power with junior colleagues;
- There was a pattern of misconduct – the targeted bullying of Witness 3, preferential treatment of Cystic Fibrosis patients and the disregard of Trust's policies – over a period of time. This pattern persisted notwithstanding that it was raised by management;
- Lack of insight into her misconduct; and
- Mrs Capel's actions had the potential to put patients at risk of harm.

The panel also took into account the following mitigating feature:

- Mrs Capel admitted to some of the charges, as well as to her impaired fitness to practise, in the Case Management Form.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the misconduct which led to the findings of impairment, and the public protection issues identified, an order that does not restrict Mrs Capel's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Capel'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 Mrs Capel's registration would be a sufficient and appropriate response. The panel determined that, in light of the bullying and dishonesty elements of her misconduct, it was unable to formulate workable conditions to address the attitudinal concerns identified. The panel was also of the view that there are no practical or workable conditions that could be formulated, given Mrs Capel's stated desire to not return to nursing.

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; and*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel was satisfied that Mrs Capel's misconduct was not a single instance but was wide-ranging and spanned a period of time. The panel heard evidence from Witness 2 that Mrs Capel's targeted bullying of Witness 3 persisted until 2021, and re-emerged after the issue was addressed and the bullying had briefly stopped. The panel was satisfied that this demonstrated Mrs Capel's deep-seated attitudinal issues.

The panel noted that there is no information before it to suggest that there has been a repetition of Mrs Capel's behaviour since the incident.

However, the panel considered that it has not received any evidence indicating that Mrs Capel has developed insight, or that there is not a significant risk that she would repeat her behaviour.

Accordingly, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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?*

The panel considered that Mrs Capel's actions raised fundamental questions about her professionalism. It found that Mrs Capel's attitudinal concerns were wide-ranging and

spanned several areas of her professional practice. Firstly, Mrs Capel engaged in prolonged, targeted bullying of Witness 3 which spanned a number of years and did not stop after it was addressed with Mrs Capel. Furthermore, the panel also considered Mrs Capel's use of her position of power to pressurise Witness 4 into signing as a second checker as outlined in Charge 2, despite him initially declining to do so, and Mrs Capel knowing that this was to create dishonestly the impression that the administration of the controlled drugs had been conducted properly. The panel was satisfied that both her attitude towards her colleague and her dishonesty raise fundamental questions about her professionalism. The panel also determined that Mrs Capel's attitude towards the administration of the DNAse nebuliser, in conjunction with her attitude towards Datix reporting and the disregard for the Trust's policies on controlled drugs and medicines management reflected an indifference to adhering to proper professional processes. The panel heard from Witness 1 and 2 that Mrs Capel was reluctant to engage in further training. In addition, the panel was satisfied that Mrs Capel's preferential treatment of Cystic Fibrosis patients raises concerns about her professionalism more generally, and her ability to treat her patients fairly.

In light of the panel's findings against Mrs Capel, and the seriousness of her misconduct, the panel was not satisfied that public confidence in the nursing profession could be maintained if Mrs Capel remained on the nursing register.

The panel concluded that, in light of Mrs Capel's attitudinal issues, striking-off is the only sanction which will be sufficient to protect patients, members of the public, and maintain professional standards. Mrs Capel's actions 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 its findings demonstrate that Mrs Capel's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

This will be confirmed to Mrs Capel in writing.

Interim order

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

Submissions on interim order

Mr Dowling Hussey invited the panel to impose an interim order to account for the 28-day appeal period, in light of the panel's substantive decision.

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

Decision and reasons on interim order

The panel determined that not to impose an interim suspension order would be wholly incompatible with its earlier findings.

The panel considered the guidance on interim orders (INT-1). 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 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 suspension order is consistent with its findings on impairment and sanction.

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

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

That concludes this determination.