IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
BETWEEN:

CLAIM NO. CO/352/2016

SG
20/6/16

THE PROFESSIONAL STANDARDS AUTHORITY
FOR HEALTH AND SOCIAL CARE

Appellant

-and-

(1) THE NURSING AND MIDWIFERY COUNCIL
(2) MISS CAROLINE JANE SPENCER

Respondents

CONSENT ORDER

UPON the parties having agreed to the terms of this Order and the statement of matters set out at Schedule 1

AND UPON neither party being a child or a protected party, and the appeal not being an appeal from the Court of Protection

AND UPON reading the statement of matters relied upon by the parties in support of the Consent Order attached at Schedule 1

AND UPON the First Respondent conceding that the decision of its Conduct and Competence Committee ("CCC") dated 18 November 2015 to impose a 12 month Conditions of Practice Order on the Second Respondent by way of Consensual Panel Determination ("the Decision") was unduly lenient within the meaning of Section 29 of the National Health Service Reform and Health Care Professions Act 2002

AND UPON the parties agreeing that the First Respondent's case against the Second Respondent ought to be remitted to a differently constituted Panel of the First Respondent's CCC for a full panel hearing on the facts, misconduct, impairment of fitness to practise and sanction, with directions as set out below.

IT IS ORDERED BY CONSENT THAT:

1. The Appeal is allowed;

2. The Decision is quashed;

3. The matter is remitted to a differently constituted Panel of the CCC for a full panel re-hearing.

4. For the purposes of the hearing provided for at paragraph 3 of this Order the First Respondent is directed to address a new allegation of impairment of fitness to practise by reason of misconduct to the Second Respondent which is to include:
   a. the matters set out in the allegation which was before the CCC at the hearing on 18 November 2015;
   b. the matters set out at paragraph 34(a), 34(c) and 34(d) of the Appellant's Grounds of Appeal;

5. The First Respondent shall pay the Appellant's reasonable costs of the appeal to be subject to detailed assessment if not agreed.

6. The Appeal hearing listed for 21 June 2016 be vacated.

WE CONSENT TO AN ORDER IN THE ABOVE TERMS

Dated this the 17th day of June 2016

Capsticks Solicitors LLP	**Nursing and Midwifery Council**	**Bevan Brittan LLP**
1 St George's Road Wimbledon London SW19 4DR	1ST Floor 1 Kemble Street London WC2B 4AN	Fleet Place House 2 Fleet Place Holborn Viaduct London EC4M 7RF
Solicitors for the Appellant	**First Respondent**	**Solicitors for the Second Respondent**

By the Court

SCHEDULE 1

STATEMENT OF MATTERS RELIED UPON BY THE PARTIES IN SUPPORT OF THIS CONSENT ORDER

1 The Second Respondent is a registered nurse. On 18 November 2015, a panel of the CCC, having considered a draft Consensual Panel Determination agreement between the First and Second Respondents, made a decision which included the imposition of a 12 month Conditions of Practice Order on the Second Respondent ("the Decision").

2 The Appellant appealed against the Decision on the grounds that it was unduly lenient within the meaning of section 29 of the National Health Service Reform and Health Care Professions Act 2002. The Appellant's Grounds of Appeal are attached to this Schedule as **Annex 1**.

3 The First Respondent concedes that the Decision was unduly lenient.

4 The parties have agreed that the original Panel's decision should be quashed and an order made that the matter be remitted to a differently constituted panel of the First Respondents CCC with directions that:

(a) a new allegation of impairment of fitness to practise by reason of misconduct is addressed to the Second Respondent which is to include:

i. the matters set out in the allegation which was before the CCC at the hearing on 18 November 2015;

ii. the matters set out at paragraph 34(a), 34(c) and 34(d) of the Appellant's Grounds of Appeal.

(b) the matter should proceed to a full panel hearing and not be determined by way of Consensual Panel Determination;

(c) the documents listed at **Annex 2** shall be placed before the panel at the remitted hearing.

5. The parties agree that this Consent Order, including Schedule 1 and Annex 1 and 2, shall be provided to the First Respondent's Case Presenter and the Legal Assessor to the panel for the remitted hearing. Further, it is agreed between the First and Second Respondents that this Consent Order will not be given to the panel at any stage of the remitted proceedings.

6. The First Respondent agrees that the matters set out at paragraph 34(b) of the Appellant's Grounds of Appeal shall be drawn to the attention of the CCC as part of the First Respondent's submissions at the misconduct, impairment and sanction stages, if such stages are reached in the remitted proceedings.

ANNEX 1 to Schedule 1

Attachment: Appellant's Grounds of Appeal, dated 22 January 2016
(as manuscript amended by the Authority on 26 May 2016 at paragraph 34)

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:-

THE PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Appellant

-and-

(1) THE NURSING AND MIDWIFERY COUNCIL
(2) MISS CAROLINE JANE SPENCER

Respondents

GROUNDS OF APPEAL

Introduction

1. This is an appeal under section 29 of the National Health Service Reform and Health Care Professions Act 2002 ("the 2002 Act") against a decision of the Conduct and Competence Committee ("the Panel") of the Nursing and Midwifery Council ("the First Respondent") made on 18 November 2015, by which it made a Consensual Panel Determination ("CPD")[1] imposing a 12 month Conditions of Practice Order on Ms Caroline Jane Spencer ("the Second Respondent").

2. As set out in more detail below, the Second Respondent was alleged to have mis- or over-prescribed inappropriate medications, a substantial proportion of which were drugs of potential abuse, to five patients over a period of eight months. The main parts of the Conditions of Practice Order require the Second Respondent, for a period of 12 months, to prescribe nothing other than Botulinum Toxin A ("Botox") (which she uses for her beauty treatment practice), and to be supervised monthly.

[1] Essentially, a consent order

3. The Panel was given the following material on which to base its decision as to whether to approve the CPD proposed by the parties:

   a. A factual summary, drafted by the First Respondent and contained in the CPD itself. The Panel was not provided with the documents underlying the factual summary;
   b. A defence bundle, which contained evidence about the Second Respondent's professional development post-referral. It did not contain any information about the misconduct itself.

4. In order to ensure that the Panel had taken all material considerations into account in deciding which sanction to impose to address the misconduct in question and the resulting impairment of fitness to practise, it was essential that the case as presented to the Panel faithfully conveyed all matters relevant to the gravity of the Second Respondent's behaviour. Where any such matters appeared to be absent, it was incumbent upon the Panel to request further submissions/evidence as to those matters before approving the CPD. Without this, the Panel could not be in a position to make consequent decisions about insight, remediation, risk of repetition, the wider public interest, and thus the appropriate sanction.

5. In the present case, there were serious procedural errors, which means that the Appellant is unable to determine whether the sanction was appropriate. In short:

   a. The factual summary presented to the Panel, although it recorded the factual allegations against the Second Respondent, was incomplete and significantly lacking in that it did not contextualise the allegations and thus did not convey much of the mischief of the misconduct alleged;
   b. The First Respondent failed to charge that the Second Respondent had prescribed outside of her scope of practice, prescribed unlicensed medication when she was not authorised to do so, and exposed her patients to unwarranted risk of harm, despite these being raised as causes for concern in an expert report commissioned by the First Respondent;
   c. The Panel reached a conclusion as to the Second Respondent's insight that was not open to it on the evidence available to it and/or without having due regard to the evidence before it;
   d. The matter was not suitable for the CPD procedure, because the Panel did not have sufficient information about the nature and circumstances of the misconduct alleged and so of the Second Respondent's level of impairment and/or because the First Respondent (and by extension the Panel) did not have sufficient

information about the Second Respondent's insight and whether there was an improper motive. Even when the CPD procedure was used, it was not used properly.

6. For these reasons, which are developed in more detail below, the Appellant respectfully requests the Court quash the Panel's decision and remit the matter for full (i.e. non-CPD) rehearing before a differently constituted panel.

Factual background

7. The Second Respondent is a qualified nurse, who is registered with and regulated by the First Respondent. She is also an "independent and supplementary prescriber", which means that she has an additional qualification authorising her to prescribe prescription medicines for patients. Her qualification means that she is legally privileged to prescribe any medication on the prescription medication list. However, prescribers are not generally expected to prescribe medication outside of their sphere of competence or practice and, where they do so, they would be expected to do so in a limited and controlled fashion, with appropriate checks and balances.

8. The Second Respondent runs a beauty practice known as "*Beau-Time*", which offers anti-ageing services and other aesthetic treatments such as Botox/dermal fillers, micro-pigmentation, and tooth whitening. The nature of her practice would ordinarily require her to prescribe Botox only. The Second Respondent is not known to have any other nursing practice.

9. Between April and December 2013, the Second Respondent wrote a series of inappropriate private prescriptions for five patients at her *Beau-Time* practice, described in the paperwork as Patients A to E. Unusually, the Second Respondent went to pick up each of these prescriptions herself rather than allow her patients to do so. To summarise:

    a. For Patients A to C, the Second Respondent prescribed unusually long courses (for 28 or 56 days) of Diazepam (an anxiolytic controlled drug of potential abuse which can cause dependence) in unusually high doses. The records of when and how the medication was to be taken, which appear in (i) the prescription itself; (ii) the Second Respondent's contemporaneous records of her consultations; and (iii) in a later annex produced by way of response to the allegations against her, were highly inconsistent with one another so as to make it impossible to discern when, how, in what quantities, and for what purpose, medication was in fact

administered. However it was administered, on any view the Second Respondent retained a substantial proportion of the tablets without ever administering them to her patients;

b. Patient D was an alcoholic who needed medication to help with alcohol withdrawal and prevent relapse. She was visiting the Second Respondent's area on a holiday, but claimed that she had left her medication at home. The Second Respondent prescribed Vitamin B Compound Strong (for alcohol detoxification) and Chlordiazepoxide (used to treat symptoms of alcohol withdrawal), and organised to review Patient D in a week. The treatment of alcohol withdrawal was unconnected to any services offered by Beau-Time and outside the scope of the Second Respondent's practice. The prescriptions were for longer periods than necessary while Patient D was away from home, where it was stated Patient D's ordinary medication was;

c. Patient E had repeat prescriptions from her GP for Omeprazole (used to treat gastric complaints), Zopiclone (used short-term to treat acute insomnia), and Amitriptyline (used to treat neuropathic pain, but unlicensed for this purpose). She had a GP appointment in one week to review these repeat prescriptions. Without contacting Patient E's GP, the Second Respondent prescribed a triple dose of Omeprazole, 56 tablets of double-dosage Zopiclone, and 84 tablets of Amitriptyline.

10. On 15 November 2013, a dispensing pharmacist at Lloyds Pharmacy became suspicious and referred the matter to the First Respondent. She was concerned about the strength and quantity of drugs (many of which were drugs of abuse) being prescribed, and about the fact that the Second Respondent herself would collect dispensed medications, rather than the patients for whom the medication had been prescribed.

11. The Second Respondent's case was that:

a. The Diazepam prescriptions for Patients A, B and C were intended to treat the relevant patients for pre-treatment anxiety and/or needle phobia. She had advised these patients to take one pill the evening before a treatment, and a second a few hours prior to treatment. The Second Respondent would prescribe enough pills for an entire course of treatment, which often involved a series of procedures over several months, but then keep the medication at her own premises to be administered by her on a treatment-by-treatment basis;

b. The excessive prescriptions of Diazepam for Patient A, which outstripped what even the Second Respondent said was needed for her total course of treatment, were written because the Second Respondent anticipated that Patient A might

request further treatment in future. No similar explanations were provided for the excessive prescriptions of Diazepam for Patients B and C, other than to point out that these were never in fact administered to the patients;

c. She accepted that, with the benefit of hindsight, it had been inappropriate for her to prescribe to Patient D in that it was outside of her sphere of expertise, but she had tried to control Patient D's access to the prescription in question by administering a week's worth of it only and then organising a review, and had telephoned Dr Bashir Butt of Derby Specialist Alcohol Misuse Service for advice;

d. She accepted that, with the benefit of hindsight, it had been inappropriate for her to prescribe to Patient E when Patient E was unable to obtain medication from her GP. At the time, she had thought her training and experience had given her the relevant expertise.

Expert report of Samantha Boobier

12. On 6 October 2014, as part of the First Respondent's investigation into the Second Respondent's activities prior to consideration by the First Respondent's Investigating Committee, the First Respondent obtained the nursing expert report of Samantha Boobier RN, BSC (Hons) MSC (also an independent/supplementary prescriber). That report sought to contextualise the allegations by placing them in their relevant factual and regulatory context. Ms Boobier made the following observations:

a. There was no clear documentation regarding the actual administration of medication to patients. The Second Respondent's claimed administration and stock levels did not correspond, and there were "*gross inaccuracies*" in the Second Respondent's account of these matters[2];

b. There was no explanation as to how, if in relation to Patients A to C the Second Respondent stored medication in her own premises to be administered on a treatment-by-treatment basis, those patients could have taken the medication the *night before* treatment and *1 to 2 hours prior to* treatment, as advised[3];

c. Several of the drugs prescribed and practices adopted could cause patient harm:

   i. The double dose of Zopiclone for Patient E for longer term use could have "*concerning consequences*", especially given that Zopiclone is not licensed for long-term use[4];

[2] Expert Report, page 14
[3] Expert Report, page 14
[4] Expert Report, page 14

ii. The prescription of Diazepam to Patient B, who also took Fluoxetine (an antidepressant), was "*of great concern, due to the accumulative sedative effects*"[5];

iii. The prescription of Amitriptyline to Patient E for neuropathic pain, when it is not licensed for that purpose[6];

iv. In respect of Patients D and E, she had prescribed long courses of types of medication likely to cause dependence or misuse, without doing anything to mitigate the risk that they were addicts who were simply trying to get medication from the Second Respondent[7];

v. The Second Respondent did not communicate her prescribing/administration of drugs to the relevant patients' GPs. This might mean a patient was prescribed the same drug twice. This raised a concern given the addictive nature of some of the medication prescribed[8];

d. It was unclear why the Second Respondent prescribed Diazepam in such large quantities (in terms both of dosage and length of course) for the relatively minor and painless procedures which her business carried out. The amount prescribed would be regarded as heavy sedation[9].

13. Ms Boobier additionally considered that the Second Respondent had acted outside the scope of her practice as follows:

a. She prescribed alcohol withdrawal medication, attempted to monitor the situation, and restricted the supply of medication that she prescribed, when she ought to have referred the patient to a GP. Arranging a follow-up after a week was "*very much outside her scope of practice and very inappropriate*"[10];

b. She "*very inappropriately*" prescribed medications for a patient who reported that she was unable to access her usual prescriptions from her GP, without relevant knowledge of the patient's health and medical history. The Second Respondent did not inform the GP practice that she had done this[11];

c. The prescriptions of Diazepam appeared to be beyond what was necessary for the treatments her practice offered[12].

[5] Expert Report, page 16, para 3.5.2
[6] Expert Report, page 18
[7] Expert Report, page 16
[8] Expert Report, page 24
[9] Expert Report, page 20
[10] Expert Report, page 22
[11] Expert Report, page 22
[12] Expert Report, page 20

14. Ms Boobier advised that it was "*paramount*" that all of the Second Respondent's patient and prescription records since she started business be reviewed[13]. It does not appear that this has ever been done.

15. Ms Boobier's expert report was not put before the Panel.

Allegations

16. The allegations put before the Panel were that, in relation to each patient and each type of medication:

> "(1) *You prescribed [x drug] with the incorrect dosage and/or frequency and/or quantity on [date]*
> (2) *You did not keep sufficient and/or accurate records in relation to the prescribing and/or administering of [x drug]*
> (3) *You did not provide sufficient and/or accurate information in relation to the prescription of [x drug]*"[14]

17. There were no allegations that the Second Respondent had acted outside of her remit, potentially exposed patients to unwarranted risk of harm, or prescribed unlicensed medication when she was not authorised to do so.

Factual Summary in the CPD

18. The agreed factual summary put before the Panel for the purposes of the CPD was as follows. It is cited in full as, other than the allegations themselves and the Second Respondent's evidence of the remedial work she had done since the misconduct in question, it represents the complete set of facts that was before the Panel.

> "2.4 ... *Enough Diazepam was prescribed for one tablet daily for each of the patients. The aesthetic treatments were minor procedures and therefore such a large quantity of Diazepam was not required. The strength and quantity of Diazepam prescribed was incorrect and inappropriate*
>
> *(...)*

[13] Expert Report, page 30, para. 5.1
[14] For the sake of completeness, there were additional charges that (a) in respect of Patient D, the Second Respondent "*inappropriately arranged a follow up appointment on 31 October 2013*" and (b) "*did not keep adequate policies and/or procedures in relation to your prescribing practice*". This second of these two allegations was later dropped.

2.6 Additionally, there were inconsistencies in the information provided on the prescriptions. Patient A's prescription of 11 July 2013 stated that 2 x 10mg Diazepam tablets were to be taken daily. The prescription of 31 October 2013 stated that 1 tablet of Diazepam was to be taken daily. Furthermore, the correct instruction on when and in what frequency the drug was to be administered was not on the actual prescription. Patient A had 10 aesthetic treatments, meaning that 20 tablets should have been administered. However, there is no documentation recording the doses of Diazepam being administered.

2.7 Miss Spencer prescribed Patient B Diazepam on 2 October 2013. This patient had a history of depression. For Patient B it was documented that 56 Diazepam tablets were received, however the amount administered was recorded as 21 tablets. It was stated in the Registrant's records that one tablet was to be taken on the eve of treatment and another tablet 1-2 hours before treatment. The prescription written for the Diazepam was inaccurate, stating that the medication was to be taken 1 daily and 56 tablets being supplied, indicating that 1 Diazepam tablet would be taken daily for 56 consecutive days.

2.8 Patient C had a history of anxiety, needle phobia and fainting, and had previously taken Diazepam for anxiety. The patient was to undergo 4 hours of treatment and a mild sedative was offered. The Registrant prescribed Diazepam for the patient on 26 July 2013 and 14 November 2013.

2.9 The directions given for administering the Diazepam were unclear, suggesting the patient should take 1 tablet every day for the next 28 days. However on the record it is recorded that the patient will take 1 tablet on the eve of treatment and 1 tablet 1-2 hours prior to the treatment. It wasn't documented in the patient's records what dose of Diazepam was taken or at what time. Given the treatments that the patient received the patient should have taken 2 tablets per treatment totalling 10 tablets, as opposed to the 20 tablets prescribed.

Charge 4

2.10 Patient D was an alcohol dependant patient needing medication to help with alcohol withdrawal and to prevent relapse. The patient was reported to have left her medication at home but does not record which beauty treatment the patient was hoping to access, with the documentation indicating that the medication was solely to treat alcohol dependency.

2.11 On 31 October 2013 the Registrant prescribed for Patient D Vitamin B Compound Strong, a standard part of treatment for alcohol detoxification. The quantity of tablets prescribed was greater than required and for a longer period than the 10 day period Patient D intended to remain in the area before heading home. The prescription did not include directions to state how many times per day this medication was to be taken or the quantity of tablets to be administered.

2.12 Additionally, the Registrant contacted Dr 1, an addiction specialist, who recommended that the Registrant prescribe Chlordiazepoxide and Vitamin B Compound Strong until Patient D went home. However, on 31 October 2013 she prescribed 100 tablets of Chlordiazepoxide, when 60 tablets should have been prescribed for this 10 day period, with 2 tablets to be taken 3 times daily.

2.13 The Registrant also arranged to review Patient D after one week rather than seek temporary registration with a GP, which was inappropriate.

Charge 5

2.14 Patient E was a patient who requested a repeat prescription. A doctor's appointment was made as a review of the repeat prescription was made. It was documented by the Registrant that Patient E took Omeprazole daily, however on 11 July 2013 the Registrant then proceeded to issue a prescription for the medicine to be prescribed 3 times daily. This is an incorrect frequency for Omeprazole to be prescribed.

2.15 Additionally on 11 July 2013 the Registrant prescribed this patient 56 tablets of Zopiclone to be administered 1 tablet at night and 1 tablet on the eve of treatment. The Registrant obtained 56 tablets for this patient, none of which were given. On 5 September 2013 the Registrant prescribed a further amount of Zopiclone 7.5mg tablets to the patient where she had been unable to access the medication through her GP. In total 84 tablets of Zopliclone were prescribed and obtained for this patient, and furthermore the prescription indicated the incorrect dosage was to be taken, at 2 tablets of 7.5mg at night. Insufficient records were kept as to the administering and prescribing of this medication.

2.16 Additionally on 12 April 2013 the Registrant prescribed Patient E Amitrptyline to the amount of 84 10mg tablets. This amounted to three months supply of the drug, when

the patient was to access her GP in one week. This prescription was not listed in the Registrant's records

2.17 Furthermore on 12 April 2013 the Registrant prescribed 368 Ibuprofen, a medication that would be more appropriately bought over the counter in the circumstances. This prescription was not listed in the Registrant's records.

2.18 None of the prescriptions which were written were given to the Patient to collect herself.

19. Thus, the factual summary presented to the Panel failed to address the following concerns raised by the First Respondent's own expert:

    a. The "*gross inaccuracies*" in the Second Respondent's response on the matter of administration vs stock levels, and that on any view the Second Respondent retained a substantial quantity of the unadministered medication without apparent explanation (see paragraph 12(a) above);
    b. How the drugs could be both (i) held at the Second Respondent's clinic; and (ii) administered pre-medication on a treatment-by-treatment basis;
    c. The fact that a substantial proportion of the prescriptions were for drugs of abuse and/or drugs which can cause dependence;
    d. Where and how, in respect of each of these allegations, the Second Respondent fell below the appropriate professional standard.

20. None of these points were mentioned in oral submissions.

21. Without knowledge of these issues, the Panel could not have had a full appreciation of the nature and circumstances of the Second Respondent's misconduct, and so were not in a position to decide on matters such as insight, impairment, or appropriate sanction.

The proceedings

22. After being presented with the provisional CPD, the Panel sought clarification on a number of matters including, relevantly, "*whether there's been any consideration about the apparent discrepancy between the number of tablets dispensed and the number administered in charge 1 and 2*"[15]. This was one of the queries raised but left open in the report of Samantha Boobier. The parties responded by simply reiterating that the

[15] Transcript, page 7, lines 6-8

Second Respondent had the practice of retaining the entire prescription and administering drugs on a case-by-case basis. For the reasons outlined by Ms Boobier, that did not provide a complete answer to the question[16].

Review

23. Before the expiry of the Conditions of Practice Order, another panel of the First Respondent will be required to review this matter. The panel conducting that review will not be required to revisit the original factual basis of the findings made by the Panel and will be limited by the incomplete information contained in the CPD when considering the scale of the misconduct, and consequently of the level of insight or impairment at the review. The reviewing panel in considering the Second Respondent's compliance with the Conditions of Practice Order imposed under the CPD, which does not address the Second Respondent acting outside her scope of practice and prescribing unlicensed medication, would be hindered in assessing whether the she is safe to return to unrestricted practice.

Legal framework

24. The Panel's decision was a "relevant decision" under sections 29(1)(i) of the 2002 Act.

25. Pursuant to section 29(4), the Appellant may refer a case to the High Court where it considers that:

"(a) a relevant decision falling within subsection (1) has been unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed, or both...
and that it would be desirable for the protection of members of the public for the Council to take action under this section."

26. Where a case is referred to the High Court, it is to be treated as an appeal (s.29(7)). Under section 29(8), the Court may:

(a) dismiss the appeal,
(b) allow the appeal and quash the relevant decision,

[16] As the Panel did not have the report of Samantha Boobier, it may well not have been aware that, even on that explanation, there remained "*gross inaccuracies*" in the Second Respondent's case on this point.

(c) *substitute for the relevant decision any other decision which could have been made by the committee or other person concerned, or*

(d) *remit the case to the committee or other person concerned to dispose of the case in accordance with the directions of the court,*

and may make such order as to costs... as it thinks fit.

27. In *Ruscillo v Council for Regulation of Healthcare Professionals [2004] EWCA Civ 1356,* the Court of Appeal held that the criteria to be applied by the Court in deciding whether to allow an appeal are the same as those applied by the Authority in determining whether the decision was unduly lenient:

"73. The role of the Court when a case is referred is to consider whether the disciplinary tribunal has properly performed its task so as to reach a correct decision as to the imposition of penalty. Is that different from the role of the Council in considering whether a relevant decision has been 'unduly lenient'? We do not consider that it is. The test of undue leniency in this context must, we think, involve considering whether, having regard to the material facts, the decision reached had due regard for the safety of the public and the reputation of the profession...

76. ... We consider that the test of whether a penalty is unduly lenient in the context of section 29 is whether it is one which a reasonable tribunal having regard to the relevant facts and to the object of the disciplinary proceedings could reasonably have imposed.

77. In any particular case under section 29 the issue is likely to be whether the disciplinary tribunal reached a decision that is manifestly inappropriate having regard to the practitioner's conduct and interests of the public

78 ... Where all material evidence has been placed before the disciplinary tribunal and it has given due consideration to the relevant factors, the council and the court should place weight on the expertise brought to bear in evaluating how best the needs of the public and the profession should be protected. Where, however, there has been a failure of process, or evidence is taken into account on appeal that was not placed before the disciplinary tribunal, the decision reached by that tribunal will inevitably need to be reassessed."

28. The Court should also allow an appeal where there has been serious procedural or other irregularity, such that it is not possible to determine whether the underlying decision as

to sanction was unduly lenient or not. This includes under-prosecution. (See *Ruscillo* at [72] and [79] – [81])

29. Where under-prosecution is raised, the questions to be asked are:

    a. On the evidence, applying its own rules, should the regulator have included further allegations in the charge; and
    b. If so, did the failure to include those allegations in the charge mean that the Appellant is unable to determine whether the sanction was unduly lenient or not? (per Lang J in *PSA v (1) GCC (2) Briggs* [2014] EWHC 2190 (Admin) at [21]).

Grounds of Appeal

Ground 1: Incomplete consensual panel determination: provisional agreement

30. As far as the misconduct itself was concerned, the only facts of which the Panel was made aware were those contained in the factual summary included in the CPD. The Panel was therefore reliant on that summary faithfully conveying the full extent of the admitted misconduct, so that it could make an appropriate decision as to sanction.

31. The allegations, together with the factual summary, did state the material facts, but what they failed to do was provide the relevant factual and regulatory context. Only when placed in context could the full import of the facts alleged be understood.

32. The First Respondent had the expert report of Samantha Boobier dated 6 October 2014, which had contextualised the allegations and led to the concerns summarised at paragraphs 12 and 13 above. Unfortunately, the expert report was not put before the Panel. Paragraph 19 above sets out the concerns raised by Ms Boobier which were not then put before the Panel one way or another. Those concerns are capable of giving the admitted facts a much more serious complexion and could have constituted additional charges.

33. In the circumstances, the Panel could not have appreciated the full significance of the admitted misconduct, and could not therefore have made safe findings on the questions of insight, impairment, and ultimately sanction. The Appellant is therefore unable to know whether the sanction imposed was unduly lenient or not, and invites the Court to quash the Panel's decision and remit the matter for re-hearing.

Ground 2: under-prosecution

34. On the evidence available to it, in particular in the expert report of Samantha Boobier, the First Respondent ought to have charged but did not charge that the Second Respondent:

a. Acted outside the scope of her practice;
b. Exposed her patients to unwarranted risk of harm;
c. Prescribed unlicensed medication without appropriate authority;
d. ~~Complied~~ with her own policies and procedures in relation to her prescribing practice.

Cpsluds 26/05/16 Failed to comply

35. It is not clear why these matters were not separately alleged. Had they been, and had they been determined against the Second Respondent, the Panel's attention would likely have been drawn to the following matters:

a. The seriousness of prescribers acting outside the scope of their practice;
b. The seriousness of prescribers failing to communicate with other clinicians involved in the care of patients;
c. A substantial quantity of the medication prescribed, whether administered or not, was medication that can create a dependency and is open to abuse;
d. The need to impose a sanction to address the risk of the Second Respondent acting outside of her practice.

36. There is a real likelihood that the sanction imposed would have been more restrictive. In the circumstances, the Appellant is unable to know whether the sanction imposed was unduly lenient or not, and the Court is invited to quash the Panel's decision and remit the matter for re-hearing.

Ground 3: lack of evidence as to insight

37. The evidence supplied by the Second Respondent as to her insight was limited to reflective learning. There was no evidence of here awareness of the impact of her actions on patients or on the public interest in safe and controlled prescribing practices. Indeed, the Second Respondent's only two sets of representations, by letter dated 14 December 2013 from herself and by letter dated 28 November 2014 from her representatives, neither of which appear to have been before the Panel, showed attempts to explain away most of the misconduct rather than any insight or contrition.

38. The Panel's conclusion, however, was that "*the admission of impairment demonstrates insight in your practice*"[17]. It appears, therefore, that the Panel took account only of the Second Respondent's admission of impairment and not of (a) the level of misconduct/impairment to which the Second Respondent was admitting (as to the problems in identifying which, see the two grounds above); (b) the lack of any evidence that she had insight into the impact of her actions on patients or on the responsibility accorded to an independent prescriber; and (c) the apparent lack of contrition in respect of many of the matters alleged, in both of the sets of representations which the Second Respondent had made in December 2013 and again a year later in November 2014 , and in the information she provided to the Panel[18].

39. Further, the Second Respondent was given credit for remaining in practice, compliantly, when in fact she had to practise in a compliant way because of the strict terms of an interim set of conditions that had been imposed on her pending this hearing.

Ground 4: Inappropriateness of CPD in the circumstances of this case

40. Insofar as any material facts in relation to the circumstances and/or context of the misconduct, the Second Respondent's attitude to it and/or her insight, were not clear – to the First Respondent following its investigation, or to the Panel on the basis of the agreed statement of facts - the case should have been referred to a full panel and not determined by way of consensual determination.

41. Paragraph 26 of the First Respondent's Guidance on Conditions of Practice (May 2012) makes the obvious point that "*The panel may also reject the provisional agreement if it considers essential information is not available to decide on an appropriate outcome.*" In the present case, the factual summary provided to the Panel strongly begs several questions which, it is submitted, were essential information for being able to decide on an appropriate outcome:

    a. Was there an improper motive?
    b. What did the Second Respondent do with medication that she prescribed but did not administer?
    c. Was there a risk of patient harm, and to what extent did the Second Respondent appreciate this?
    d. Was the Second Respondent's account credible?

[17] Determination, page 22
[18] Transcript, page 10, line 24

42. With the exception of the second of the above questions, the Panel ought to have but did not probe any of these matters before approving the CPD.

43. Moreover, paragraph 28 of the First Respondent's Guidance on Consensual Panel Determination (March 2015) provides that "*If the further information is not available, and the panel considers it is essential, they will reject the provisional agreement...*" As observed above, the Panel asked the parties for an explanation as to the discrepancy between the amount of medication prescribed and the amount administered. The response provided was the same as that which had been provided to Ms Boobier, who with the benefit of a fuller set of facts had considered that the response was "*grossly inaccurate*" (see paragraph 12(a) above).

44. Even once the CPD procedure was used, it was not used properly in that, for the reasons given above under Ground 3, the evidence of the Second Respondent's insight was neither full nor clear. In the circumstances, this matter should have been heard at a full hearing before any decision was taken.

45. The matters encompassed by the full context of the Second Respondent's misconduct which were not placed before the Panel (either in the CPD agreement or the charges brought by the First Respondent) were of such importance to the need to maintain public confidence in the nursing profession and to declare and uphold professional standards, that it would have been in the public interest for the case to be heard at a full hearing, rather than resolved by way of CPD.

46. In all the above circumstances, the Panel was not in a position to reach safe conclusions as to the level of misconduct, insight, impairment, and ultimately sanction.

Conclusion

47. For the reasons set out above, the Appellant respectfully asks the Court to allow this appeal, quash the decision of the Panel and remit the matter to a differently constituted panel with directions that (i) the charge should be amended to reflect the additional allegations of acting outside the scope of her practice, prescribing unlicensed medication without authority to do so, and exposing patients to unwarranted risk of harm, referred to above and (ii) the matter should proceed to a full panel hearing.

Benjamin Tankel
39 Essex Chambers
22 January 2016

ANNEX 2 to Schedule 1

Documents to be placed before the panel at the remitted hearing

1. Papers before the First Respondent's Investigating Committee, including in particular the following documents:

   a. Letter from the Registrant dated 14 December 2013;

   b. Expert report of Samantha Boobier dated 6 October 2014.

2. Bevan Brittan LLP's letter on behalf of the Registrant dated 28 November 2014.

3. The First Respondent's Indicative Sanctions Guidance in force at the relevant time.

Claim No: CO/352/2016

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

BETWEEN:

THE PROFESSIONAL STANDARDS AUTHORITY
FOR HEALTH AND SOCIAL CARE
Appellant

-and-

(1) THE NURSING AND MIDWIFERY COUNCIL
(2) MISS CAROLINE JANE SPENCER
Respondents

CONSENT ORDER

Capsticks Solicitors LLP
1 St Georges Road
London
SW19 4DR

Ref: KQS/103487

Solicitors for the Appellant