Neutral Citation Number: [2016] EWHC 1983 (Admin)

Case No: CO/1363/2016

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/07/2016

Before :

MR JUSTICE WYN WILLIAMS

- -

Between:

Professional Standards Authority for Health and Social Care	**Appellant**
- and -	
The Nursing and Midwifery Council and David Andrew Dalton	**Respondents**

- -
- -

Peter Mant (instructed by **Browne Jacobson LLP**) for the **Appellant**
Aja Hall (instructed by **NMC Legal Services**) for the **First Respondent**
Christopher Geering (instructed by **RCN Legal Services)** for the **Second Respondent**

Hearing date: 20 July 2016

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Approved Judgment

Judgment Approved by the court for handing down.

Mr Justice Wyn Williams :

Introduction

1. Section 29 of the National Health Service Reform and Healthcare Professions Act 2002 confers upon the Appellant the right to refer to this court fitness to practise decisions taken by the First Respondent in relation to nurses and midwives. The reference is by way of an appeal. On 7th January 2016 a Conduct and Competence Committee of the First Respondent ("the Panel") found that the Second Respondent's fitness to practise was impaired on account of misconduct and determined that he should be the subject of a caution order for a period of two years. This finding and the sanction imposed were made with the consent of the Second Respondent as a consequence of a procedure known as a Consensual Panel Determination.

2. On 11th March 2016 the Appellant exercised its right to appeal to this court. The Appellant asserted that the First Respondent's decision should be quashed on the grounds that it was the product of serious procedural irregularity. A number of individual grounds were formulated to support that general proposition but, in short, the Appellant's contention was that the Second Respondent had been significantly "under-charged" in that the particulars of misconduct specified against him did not adequately reflect the extent of his misconduct. In consequence the agreed sanction was unduly lenient.

3. Both Respondents accept that the appeal must be allowed and that the decision of the First Respondent should be quashed. That has been their positions for some time.

4. In the light of this state of affairs the Appellant submitted a consent order which it invited the Respondents to sign. The First Respondent has signed the consent order but the Second Respondent declines to do so. The relevant parts of the consent order are as follows:-

> "(1) The appeal is allowed save for ground 1(c)(iv) which is dismissed.
>
> (2) The decision is quashed.
>
> (3) The First Respondent's case against the Second Respondent is to be remitted to a differently constituted Panel of the CCC for consideration of a fresh set of allegations which will reflect the concerns raised in ground one of the appeal, save for ground 1(c)(iv), and for consideration of the issues of misconduct, impairment of fitness to practise and sanction. "

5. To make sense of the order it is necessary to set out the relevant parts of ground 1 of the Appellant's grounds of Appeal. Ground 1 provides:-

> "(1) the decision of the Conduct and Competence Committee to impose a caution order upon the Second Respondent (for a period of two years) arose from a serious procedural irregularity, in that the First Respondent had failed to:-

> (a) allege that as a consequence of the Second Respondent setting an incorrect infusion rate Patient A received a 24hr dose of midazolam within approximately 1 hour….
>
> (b) allege that the Second Respondent (i) acted or failed act in the respects described in paragraph 2 of the Allegation; and/or (ii) failed to make an accurate record of the infusion of midazolam to Patient A in the clinical records, in order to mislead his employer and/or to protect his own interest;
>
> (c) allege that, on being confronted with the error referred to at (a) above, and thereafter, the Second Respondent acted dishonestly, in claiming that:-
>
> (i) the error in the rate at which the midazolam was administered to Patient A was discovered when he checked upon her, and other members of the nursing staff on the ward had drawn it to his attention;
>
> (ii) prior to the time at which he replaced the midazolam infusion for the second time on 10th March 2014 only 5-6 mg of the Midazolam infusion had been administered to Patient A, when the full dose for 24hours (30mg) had been administered;
>
> (iii) when he handed over at the end of shift on 10th March 2014 he explained what had happened, when he had not done so (the nurse assuming responsibility for the ward was told about the overdose by another member of the nursing staff); ”

These grounds will be readily understood in the light of the relevant facts.

6. As I have said, the First Respondent is content that the case should be remitted on the basis of this ground of appeal. The Second Respondent, however, disagrees. He would be content for his case to be remitted on the basis of ground 1(a) and (b) but he objects to the case being remitted on the basis of the allegation which is made in ground 1(c). As I understand it, whatever may be the truth about the factual content of ground 1(c) the Second Respondent does not accept that he acted dishonestly.

7. In order to make sense of the rival contentions it is necessary to set out some of the relevant factual material including the relevant factual disputes.

The facts

8. On 10th March 2014 the Second Respondent was employed as a Band 6 Charge Nurse at Southampton General Hospital. The ward in which he was working contained a number of elderly patients. Patient A was one such patient; it is common ground that on 10th March 2014 she was terminally ill.

9. At or about 12.30pm the Second Respondent, assisted by Ms Rainho, a more junior nurse, began infusing Patient A with the drug called midazolam. The prescription was

for 30mg of the drug to be infused over the period of 24 hours. The infusion was being undertaken with a syringe operated by a pump.

10. A comparatively short time after the infusion had begun it was discovered that the infusion was complete. Ms Rainho maintains that she made this discovery when she heard the warning "beeper" indicating that the infusion had been completed. She says that she went to investigate and that having done so she saw the words "end of infusion" on the pump screen and she also saw that the syringe was empty. Ms Rainho says that she alerted the Second Respondent as soon as she made her discovery. According to her, he responded by saying that he would investigate. She maintains that later that day the Second Respondent confirmed to her that the syringe had, indeed, been empty and accordingly he had prepared a second syringe and the drug was then administered correctly.

11. During that afternoon Ms Joanna Kirk, another nurse, was covering side rooms within the ward. She, too, says that she heard the warning beeper and investigated. She, too, says that the syringe was empty when she went to look and that she told the Second Respondent about what she had seen. Ms Kirk says that she was uneasy about what had happened. She discussed what had occurred with the Second Respondent before he went off his shift. He sought to reassure her that he "had sorted it out" but Ms Kirk remained unconvinced. When a sister, Shelley Palmer, began her night shift at 7.30pm that day Ms Kirk alerted her to what had occurred.

12. At 3pm on 10th March 2014 i.e. during the course of his shift the Second Respondent made an entry in Patient A's clinical notes. He recorded that the infusion of midazolam had been changed at 2.30pm because the rate of infusion was incorrect and that the change had taken place after about 30 minutes. This was the only note which the Second Respondent made that day about the incident.

13. On or shortly after 10 March 2014 the incident came to the notice of a senior sister, Ms Carianne Winter. On 18th March 2013 she spoke to the Second Respondent about what occurred. She says that she told him to complete an incident log.

14. It was not until 8th April 2014 that the Second Respondent completed the log. Under the heading "Incident Description" the following appears:-

> "Patient admitted to F11 for palliative care, with ongoing seizures, therefore prescribed midazolam infusion via syringe driver. Syringe in driver empty at approximately 14.00, replaced by 2 x nurses no change in prescription, 30mg over 24hrs. Midazolam prepared and placed in syringe driver. After approximately 30 minutes the syringe driver checked, rate noted to be incorrect, immediately stopped. Not all of syringe had been infused, as unsure of rate remaining syringe discarded, new syringe prepared and placed in driver at the correct rate 1.2mls/hour……."

15. By the time this incident report was made, the Second Respondent had been invited to provide a statement setting out what had happened. He had not made that statement by 8th April, i.e. by the time the incident report was completed, but he did make a "reflective witness statement" on 16th April 2014. In that statement he described how

Ms Rainho and he had set up the syringe to be used to infuse Patient A. He continued:-

> "…. I was certain that when I placed the new syringe into the pump, I cleared the previous setting, and set the rate 1ml per hour.
>
> When I checked the syringe pump after approximately 30 minutes I noticed that the rate was incorrect. I cannot recall exactly what the rate was displaying, or what was remaining in the syringe but approximately 5mls had already been infused. I immediately stopped infusion. As the drug left in the syringe was now less than 30mg/30mls, I decided to replace the whole syringe. I knew from my experience that IV midazolam has a very short life/action, and after it had been double checked, placed this into the pump making certain the rate was correct as prescribed 1.25mls per hour……
>
> I documented what had occurred in the patient's notes, and explained to SN Rainho who was taking over from me what had occurred. …"

16. In due course the Second Respondent's employers decided to instigate a formal investigation. Miss Tina Baker led the investigation. She obtained accounts from all the relevant persons, namely Ms Rainho, Ms Kirk, Ms Palmer and the Second Respondent. The accounts provide by Ms Rainho, Ms Kirk and Ms Palmer were consistent with the summary set out above. The account provided to Miss Baker by the Second Respondent was, essentially, consistent with the account which he had provided in the incident log and his reflective witness statement.

17. As is obvious, there are substantial differences between the accounts provided by the Second Respondent and the accounts provided by Ms Rainho and Ms Kirk. There is a fundamental difference between them as to whether the infusion was complete within a short time of its starting and there is also a fundamental difference as to the circumstances in which the error in the rate of infusion came to be discovered. If Ms Rainho and Ms Kirk are truthful and accurate it follows that the accounts given by the Second Respondent in the incident log, in the reflective witness statement and in answer to Ms Baker during the course of her investigation are erroneous. Plainly, it is arguable, at the very least, that the Second Respondent deliberately provided a dishonest account of some of the events of 10th March 2014 on three separate occasions.

The law

18. It is agreed that this court can quash a decision of a panel if the decision is wrong or founded upon a serious procedural irregularity. It is now well established that "significant under-charging" can constitute serious procedural irregularity - see *Ruscillo v Council for Regulation of Health Care Professionals* [2004] EWCA Civ 1356 and paragraphs 15 to 22 of the decision of Lang J in *The Professional Standards Authority v the General Chiropractic Council and another* [2014] EWHC 2190 (Admin).

19. In my judgment it is well established, too, that if an allegation of dishonesty is to be made against a registrant it should be pleaded, specifically, as an allegation of misconduct - see paragraph 26 of the decision of Lang J in *The Professional Standards Authority* case.

20. It sometimes happens that a registrant commits an act which is capable of amounting to misconduct but, thereafter, dishonestly seeks to hide or cover up what he has done. That scenario was considered in *Misra v General Medical Council* [2003] UKPC 7.

21. Dr Misra was a general practitioner in Corby, Northamptonshire. On four occasions between 22nd July and 25th July 1997 the husband of a patient made telephone calls to Dr Misra's surgery expressing significant concerns about her health. The calls were taken by Dr Misra's receptionist. In due course, the receptionist maintained that following each telephone call she conveyed the gist of the conversation to Dr Misra although she acknowledged that only two of the calls were noted in the patient's records. In due course telephone records were obtained which showed that four calls had been made as asserted by the receptionist and the patient's husband. On 18th September 997 the patient's son wrote to Dr Misra to ask him why the patient records only showed two calls when four were made. Dr Misra replied by saying that he could not explain why that was so because the receptionist had left the practice. In January 1998 a meeting took place between Dr Misra and the son in which Dr Misra appeared to suggest that he had been told of two calls, only, and the receptionist was at fault.

22. Two years went by. The patient's son then made a complaint to the GMC about Dr Misra. In response to the complaint, Dr Misra's solicitors wrote a letter in which, implicitly, it was accepted that four telephone calls had been made to the surgery but the assertion was made that only two of the calls had been brought to the doctor's attention.

23. In due course a number of allegations of misconduct were made against Dr Misra. One of the allegations was that he had knowingly provided false information to the patient's son. Another allegation was that he had knowingly provided false information to the GMC. At paragraph 17 of the judgement the Judicial Committee of the Privy Council set out its view upon the fact that these allegations had been charged as misconduct.

> "17. Their Lordships find the inclusion in the charge of allegations that Dr Misra gave information he knew to be untrue rather troubling. The substantive allegations against Dr Misra were that he had been informed of all of the four telephone calls and requests for home visits. Dr Misra admitted being informed of only two of them. So there was a substantive issue as to whether he had been informed of the other two. If he were to maintain his denial at the hearing and be believed that would be an end of the issue. If his denial were to be disbelieved then the Committee would have to consider his conduct regarding [the patient] on the footing that he had received four requests to visit her but had failed to do so and on the footing also that he had lied about two of the telephone calls. What the GMC's point was in adding to the charge first an allegation that he had earlier told the same lie [to patient's son] and secondly the lie had been repeated in the letter to the GMC is not clear. Their Lordships

> enquired of Mr Green, counsel for the GMC, whether it was a general GMC practice where charges of professional misconduct were being made to add to the factual allegations on which the charges were based an allegation of dishonesty in the event the respondent doctor had the temerity to deny any of the factual allegations. Counsel told their Lordships that it was not the general practice and that he was not aware of a previous case where that had been done. No explanation of why it thought right to add the allegations of dishonesty in the present case was offered. In their Lordships opinion the addition of the allegations of dishonesty in the present case was unnecessary and oppressive. The allegations add nothing to what would have been shown to be the degree of culpability of Dr Misra if the substantive allegations that he had declined to admit were found proved against him. "

24. In my judgment *Misra* is clear authority for the proposition that if a charge or particulars of a charge are unnecessary and/or oppressive the charge or the particulars should not be brought/relied upon by the regulatory authority. If a charge or particulars alleging a dishonest cover-up of misconduct add nothing to the degree of culpability of the registrant it may well be appropriate to conclude that a charge or particulars alleging the dishonest cover-up should not be relied upon assuming that the substantive underlying charges are proved or admitted. However, in my judgment the principle in Misra does not prevent a regulatory body charging a registrant with acts which amount to a dishonest cover up of misconduct if proof of a dishonest cover up would substantially increase the culpability of the registrant.

Discussion

25. Mr Geering submits that the inclusion of an allegation of dishonesty as particularised in ground 1 (c) of the grounds of appeal would be oppressive and unnecessary. He submits that this case cannot be distinguished, in principle, from *Misra.* He says that in *Misra* the allegation was that the doctor had attempted to minimise his culpability by giving a dishonest account to the patient's son which he later repeated to the GMC in his solicitor's letter. In the instant case, submits Mr Geering, it is proposed that it should be alleged that the Second Respondent attempted to minimise his culpability by giving a dishonest account in the incident log, in his reflective witness statement and to the investigator Ms Baker.

26. I do not accept this to be the correct analysis. In *Misra* the substantive misconduct alleged was that the doctor had ignored four telephone calls in which he was being told that his patient was significantly ill and it was being requested that he make a home visit. The doctor admitted ignoring two such calls and, obviously, on the basis of the charges laid against him there would, inevitably be a resolution as to whether he had ignored only two calls, as he admitted, or four calls as was alleged. In that particular context the fact that Dr Misra asserted, subsequently, to both the patient's son and the GMC that he had received two calls only added little to the serious substantive allegations made against him.

27. In the instant case the charge considered by the Panel was as follows:-

> "That you, whilst employed by the University Hospital Southampton NHS Foundation Trust as a band 6 charge nurse and working on ward F11, on 10th March 2014;
>
> (1) At approximately 12.40pm, commenced infusion of medazolam to patient A at an incorrect infusion rate, resulting in Patient A receiving a 24 hour dose within approximately one hour
>
> (2) On realising your error as alleged at Charge 1:
>
> 2.1 At approximately 14:00 commenced the second infusion of medazolam to Patient A which was not prescribed;
>
> 2.2. Failed to escalate to medical staff;
>
> 2.3 Failed to take observations of Patient A;
>
> 2.4 Failed to promptly complete the incident report.
>
> And, in light of the above, your fitness to practise is impaired by reason of your misconduct."

28. In my judgment the allegations which the Appellant wishes the First Respondent to pursue to the effect that the Second Respondent gave dishonest accounts of the circumstances in which his error was discovered and gave dishonest accounts about the extent of the errors would, if proved, probably have the effect of substantially increasing his culpability. At the very least, there is a reasonable prospect that a panel would so conclude. That, in substance, is the basis upon which Mr Mant submits that it would not be oppressive or unnecessary to charge the Second Respondent with the allegations of dishonesty and, in my judgment, Mr Mant's submissions on this issue are correct.

29. Mr Geering points out, correctly, that the difference in accounts between Ms Rainho and Ms Kirk on the one hand and the Second Respondent on the other would, inevitably, have to be resolved by a panel whether or not specific charges are brought. If the factual disputes were resolved against the Second Respondent it would be open to the panel to treat the Second Respondent's accounts as evidence of a lack of insight which would impact upon his fitness to practise. The dishonest accounts might also be treated as aggravating features relevant to the issue of sanction.

30. I understand why Mr Geering makes these submissions but I do not consider that they provide a basis for concluding that an allegation of dishonesty would be oppressive or unnecessary. A registrant is entitled to know the full extent of any allegations of misconduct which are brought against him. In my judgment, certainly in the context of this case, fairness demands that the Second Respondent should know in advance of the hearing the full extent of the allegations of misconduct which are made against him and, further, the inclusion of specific allegations of dishonesty will ensure that the Panel addresses that issue appropriately.

31. I have reached the clear conclusion that this appeal should be allowed and that the order which this court should make is informed by the draft order already signed by the First Respondent. The probability is that the order to be made by this court should be further refined to reflect the document sent to me by Mr Mant shortly after the close of the oral hearing which made plain which accounts given by the Second Respondent were to be the subject of allegations of dishonesty.

32. I propose hand down this judgment at 10am on Friday 29th July 2016. If the parties can agree an order consequent upon this judgment there need be no attendance.