Section 29 Case Meeting

12 November 2020

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Michelle McCorry

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Kisha Punchihewa, Head of Legal (Senior Solicitor), Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny & Quality (Performance), Professional Standards Authority

In attendance
Michael May, Solicitor, Edwards & Co Solicitors**,** Legal Advisor

Observers
Kellie Morwood, Solicitor, Edwards & Co Solicitors
Seun Fagbohun, Data Administrator, Professional Standards Authority
Rachael Martin, Scrutiny Team Co-ordinator, Professional Standards Authority
Siobhan Carson, Senior Scrutiny Officer, Professional Standards Authority
Marija Hume, Head of Finance, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's Panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public

- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the Panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of Northern Ireland and the statutory time limit for an appeal would expire on 16 November 2020.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 21 September 2020.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the Panel dated 21 September 2020
- The Authority's Detailed Case Review
- Transcript of the hearing dated 21 September 2020
- Legal report by Edwards & Company Solicitors dated 11 November 2020
- Position paper of Society re undertakings
- Outcome letter to M McCorry
- IOC webnotice
- Notice of referral – DPP
- Statutory Committee evidence bundle

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

- The PSNI's Indicative Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual

7.2 The Members and the Legal Advisor were provided with a copy of a response from the PSNI to the Authority's Notification of s.29 Meeting. The Members considered the response having received legal advice and after they reached a conclusion on the sufficiency on the outcome.

8. Background

8.1 The Registrant was employed as a practice-based Pharmacist at a Health Centre and Medical Centre. The Registrant was enrolled on a foundation programme for practice pharmacists to support her transition into practice-based pharmacy and was provided with an Educational Supervisor and lead practice Pharmacist support. She was provided with two weeks full time work-based training and shadowing within the existing pharmacist team in the practices in which she would be working.

8.2 It was during this employment that concerns regarding the Registrant's fitness to practise arose.

8.3 Following several meetings with her Educational Supervisor and superiors to discuss the concerns, which the Registrant initially disputed, the Registrant eventually requested a performance improvement plan. When she eventually submitted the plan, it did not reflect her personal learning needs and an informal warning was issued and improvement plan was agreed on 21 December 2018. The Registrant appealed the informal warning. The informal warning was upheld.

8.4 On 25 January 2019 a review was undertaken by the Lead Pharmacists following a visit to the Health Centre where the Registrant worked including a review of incident reports. Nine of the incident reports raising patient safety concerns involved the Registrant although none had been reported by her. Concerns regarding her practice were escalated and at a meeting on 30 January 2019 it was decided that precautionary suspension was required in order to ensure patient safety.

8.5 Following the introduction of precautionary suspension, a review of the Registrant's work at the Medical Centre was undertaken and of the 63 records reviewed, concerns were identified with 43, ranging from minor to significant concerns.

8.6 Following the findings of this review a referral was made to the PSNI on 3 April 2019 encompassing actual and potential patient safety concerns arising from errors on the part of the Registrant. The notification of referral to the PSNI outlined the concerns arising from the nine incident reports, concerns regarding the Registrant's failure to report adverse incidents and examples of the issues arising from the review of the 63 records undertaken following her suspension.

8.7 The Registrant was subjected to an Interim Conditions of Practice Order on 18 April 2019 which was reviewed in October 2019 and discharged on 2 April 2020

on the basis of the undertakings provided and the Society's view that the Registrant was fit to practice in a community pharmacy setting as a result of her compliance with the interim conditions.

8.8 The Society's Chief Executive and Interim Registrar notified the Registrant of the referral of allegations of deficient professional performance on 7 May 2020. The particulars of deficient professional performance, included concerns on the use of incorrect dosage, use of incorrect drug, failure to discontinue medication as recommended, failure to query recommendations when required, failure to manage changes to medication appropriately failure to undertake medicines reconciliation appropriately, inappropriate discontinuation of a drug without follow up review, drug issued to wrong patient and a failure to report adverse incidents.

8.9 The Statutory Committee accepted the undertakings proposed under which the Registrant agreed for a period of seven years to work only in a community setting and not to undertake independent prescribing work.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

Charging

9.3 The Members considered whether the approach in treating the case as deficient professional performance and not misconduct was correct and whether the case should have been considered as both or solely as misconduct. The Members considered the guidance from the Court on what constitutes deficient professional performance. The Members noted that the Registrant's employer had reviewed the majority of her work as part of its investigation. There was an argument to be made that this case could have included a charge of misconduct but the Members were minded that in performance cases the deciding Panel do not have the option of removal available to them whereas in misconduct cases they do. The Members considered that in this case the Registrant's failings where not likely to have resulted in removal.

9.4 The Members felt that the fact that the Registrant had been subject to Interim Order Conditions had benefited her in that she had been supervised and able to improve her practice such that it was not clear that, even if there had been a charge of misconduct, the Registrant could have put forward a case that these had at the date of this hearing remedied those concerns. The Members noted that the concerns were isolated to one place of employment with no concerns being raised before or since the material time referred to in the allegations. The evidence before the Interim Order Committee also confirmed that she had been working at an acceptable level in Community Pharmacy.

9.5 On that basis the Members concluded that it was not wrong for the PSNI to have treated this as purely a deficient professional performance case.

9.6 The Members also considered whether there was a failure to allege "attitudinal failings" in relation to the Registrant's lack of cooperation with her employer in terms of addressing the concerns in her practise and her failure to recognise her errors and mistakes. The Members considered that the PSNI could have included allegations regarding the Registrant's lack of engagement and willingness to address the concerns identified in her practise by her employer. However, the Members felt that had this been alleged, a finding of current impairment would not necessarily have been made because while she was not willing or capable of reflecting on her practice at the time, there was now sufficient evidence that she had accepted the criticism. There was no evidence from her current supervisors of concerns in this area of practice.

9.7 Finally, Members also considered whether there was a failure to allege a breach of duty of candour in that the Registrant had a duty to report her failings which she failed to do. The Members felt that the evidence suggested that at the material time the Registrant was not aware of the mistakes she was making in her practice and in the circumstances, it was therefore not unreasonable for the PSNI not to have included such an allegation.

9.8 The Members concluded that there were no significant procedural errors in terms of the charges. Whilst Members considered that there was evidence to suggest that at the time the Registrant displayed attitudinal issues in relation to her cooperation in terms of addressing her deficiencies with her employer, Members were not satisfied that had this formed part of the charges that it would have made any material difference to the overall outcome when considering the current evidence in terms of the Registrant's practice.

Process

9.9 The Members considered whether there was sufficient evidence of the necessary level of scrutiny by the Panel in terms of the Registrant's deficiencies, remediation and investigations of all the evidence. The Members acknowledged that they were limited in terms of commenting on the level of investigations since there was limited evidence of such. However, the Members were minded that evidence pointed towards the Registrant having a lack of insight and engagement with support mechanisms, yet the Panel concluded that she was capable of self-directed remediation. Furthermore, the rationale set out in the decision by the Panel suggested the Panel failed to consider whether reviewable conditions were a more appropriate measure to deliver the necessary public protection and measures for remediation.

9.10 The Members were concerned by the Panel's comment that they had their own *"misgivings about the Registrant's community practice"*[2] which were not elaborated on. The Members noted that it was the Panel's role to ensure the overarching objectives were upheld and although presented with proposed undertakings they should have continued to address their own concerns through questioning.

9.11 The Members concluded that as they were unable to determine the nature of the Panel's *"misgivings"* they were not in a position to be able to definitively

[2] Transcript page 24

conclude that any further scrutiny and investigation by the Panel would have resulted in a different outcome. There were, however, flaws in the Panel's approach following their decision to accept the proposed undertakings and ultimately fail to carry out their enquiry role.

Expert witness

9.12 The Members considered the expert's report and in particular whether the expert was instructed on too narrow a basis. The Members acknowledged that the expert witness appeared not to have undertaken his own independent review and analysis of the concerns raised in the registrant's practise. He appeared essentially to have been asked to validate the approach of the Panel thereby potentially undermining his independence and arguably usurping the role of the Panel.

9.13 The Members considered that the Panel appeared to have treated the expert witness as their own clinical advisor to assist them in determining the seriousness of the allegations and to support them in their decision making. The instructions to the expert did not seek to elicit what standard the Registrant should have been working at and whether or to what extent she had breached any standards. Nevertheless, the Members noted that the report did contain extracts whereby the expert witness provided an opinion on the Registrant's practice and on her competences.

Deficiencies

9.14 The Members discussed whether there was sufficient evidence that the range of deficiencies identified in the Registrant's practice at the material time had been adequately addressed.

9.15 The Members noted that they were largely reliant on the expert witness' report when determining whether the Registrant's deficiencies had been addressed. The Members considered the commonality between Community based pharmacy and Practise based pharmacy was the importance of error and near miss reporting which the Registrant had not addressed whilst under investigation with her employer. However, this was a deficiency which the Members were satisfied that the Registrant was now alive to and there was evidence of this being addressed in reports from her current supervisor. It was also noted that ensuring the patient was receiving the correct dose of medication was a skill relevant to both areas of pharmacy. The Members noted that the Registrant has completed a great deal of CPD although there was no evidence that this learning has been embedded in her actual practise. This therefore remained an area of risk. However, Members were mindful that the undertakings prevented the Registrant from working in such an environment.

9.16 The Members considered that whilst it was right that the Registrant had been able to address a number of the issues about her practice, there still remined some deficiencies.

Risk

9.17 The Members considered whether the Registrant continues to pose a risk by practising under the restrictions imposed by the undertakings and whether the undertakings provided sufficient safeguards.

9.18 The Members were satisfied that there was no substantive evidence that the Registrant poses a risk to patients with the undertakings in place. Members were also reassured that should the Registrant wish to remedy the outstanding deficiencies as a Practice based pharmacist, she was first required to notify the Registrar of this, and the undertakings would be modified to allow her to work in a practice based pharmacy setting.

9.19 The Members were also minded there was a level of cross over between conditions and undertakings. The main distinction being that conditions would include a requirement for regular reporting to the PSNI. The Members concluded that there were not able to identify a tangible area of risk which undermined the decision to impose undertakings. The Registrant had clearly addressed a number of areas of her deficient practice and it could not now be said that she lacked the insight she had previously shown.

Conclusion on insufficiency for public protection

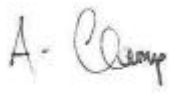
9.20 The Members considered the Panel's approach during the hearing and failure to fully carry out their enquiry role concerning, however, they concluded that the decision was not one which no reasonable Panel could have made. In all the circumstances, therefore, it was not insufficient for public protection.

10. Referral to court

10.1 Having concluded that the Panel's Determination was not insufficient for public protection, the Members were not required to consider whether they should exercise the Authority's power under Section 29 to refer the case to the relevant court.

11. Learning points

11.1 The Members agreed that the learning points set out at Appendix C should be communicated to the Regulator.



30 November 2020

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Alan Clamp (Chair) **Dated**

12. Annex A – Definitions

12.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	The Statutory Committee of the Pharmaceutical Society of Northern Ireland
The Registrant	Michelle McCorry
The Regulator	Pharmaceutical Society of Northern Ireland
PSNI	Pharmaceutical Society of Northern Ireland
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on 21 September 2020
The Court	High Court of Justice of Northern Ireland