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Case No: CO/2535 & 2536/2012

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/07/2013

Before:

MR JUSTICE LEGGATT

- -

Between :

(1) Sarah Elizabeth Johnson **(2) Lynette Maggs**	**Claimants**
- and -	
Nursing and Midwifery Council	**Defendant**

- -

(Transcript of the Handed Down Judgment of
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Mary O'Rourke QC and Nadia Motraghi (instructed by **Radcliffe Le Brasseur**) for the **Claimant**
Lynn Griffin (instructed by **Ward Hadaway**) for the **Defendant**

Hearing dates: 24-25 April 2013

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Mr Justice Leggatt :

Introduction

1. The disciplinary proceedings which are the subject of this claim for judicial review could unfortunately serve as a case study for how a disciplinary case should not be conducted.

2. The disciplinary case was brought by the Nursing and Midwifery Council ("the NMC") against Sarah Johnson and Lynette Maggs, both of whom are registered nurses and whom I shall refer to as "the registrants". The NMC charged the registrants with misconduct. The misconduct was said to have occurred during the period 1 October 1998 to 31 January 2002 when the registrants were, respectively, the Manager and Deputy Manager/Matron of a nursing home called Lynde House in Twickenham ("the Home"). The chronology of the case makes unhappy reading.

Chronology of the Disciplinary Case

3. The registrants were first notified that they were the subject of allegations by letters from the NMC dated 25 September 2003. Those letters informed the registrants that the NMC had received allegations of misconduct which might lead to the removal of their names from the register, and summarised the allegations. These were 10 in number, all expressed in extremely general terms.

4. The NMC then carried out an investigation. This took over two years. On 13 December 2005 the case was referred for hearing to the NMC's Professional Conduct Committee. It was only on 30 April or 1 May 2007 – over 3 ½ years after they had first been notified of the allegations against them – that the registrants were sent the charges in their final form. The charges related to 15 individuals each of whom had been a resident in the Home during some part of the period 1 October 1998 to 31 January 2002.

5. The hearing before the Professional Conduct Committee commenced on 30 July 2007. The registrants objected to the case against them, principally on the grounds that the charges lacked particularity and that the NMC had failed to obtain documents which it was said they should have obtained and made available to the registrants. The registrants applied for the case to be stayed. That application was rejected by the Committee on 8 August 2007.

6. The registrants applied for judicial review of the Committee's decision and the disciplinary proceedings were stayed until the claim for judicial review had been determined. A rolled up hearing of the application for permission to proceed and the substantive claim for judicial review took place on 4-6 March 2008 before Beatson J, who refused the application.

7. On 23 July 2008 a directions hearing took place before a reconstituted panel of the NMC's Professional Conduct Committee. A hearing date for the disciplinary case was set for 2 February 2009, with a time estimate of 45 days. The hearing was to be split into three parts, to fit in with the availability of the members of the Committee, and was scheduled to end in late June 2009. In the event the presentation of the NMC's case was only just completed by the end of the allotted period. Further sessions had to be scheduled for the registrants and their witnesses to give evidence, submissions made and the Committee to reach its decisions. These sessions were intermittent, to fit in with the availability of the members of the Committee and of counsel, and there were many further delays and interruptions.

8. The hearing was finally concluded on 9 December 2011. In all, the hearing lasted a total of 86 days spread over a period of two years and nine months. By the time the Committee made its decisions, the events which were the subject of the charges were between 13 and 9 years old. The total time which elapsed from when the registrants were notified of the allegations until the conclusion of the disciplinary proceedings was over 8 years.

9. When the case ended on 9 December 2011, the NMC issued a public statement which announced the result and said:

> "We fully understand the anxiety and distress that the delays in the handling of this case have caused to all the parties involved and offer our sincere apologies for the unacceptable length of time it has taken to reach a conclusion.
>
> We are confident that if similar allegations were referred to the NMC today, changes in our rules and processes would mean that the cases would be completed much more quickly."

10. Whether this confidence is justified or not, it is of no consolation to the registrants. Before this court the NMC accepted – as in the circumstances it was bound to do – that the delays in the conduct of the proceedings violated the right of the registrants under Article 6 of the European Convention for the Protection of Human Rights to a hearing within a reasonable time. Counsel for the NMC, Ms

Griffin, provided an analysis of the delays which indicated that they were caused by a variety of factors. The Committee itself, when it rejected (on Day 73) an application to stay the disciplinary proceedings on the ground that they had by then become an abuse of process, identified the causes of the delays as being: (i) the complexity of the case; (ii) the conduct of the defence; (iii) the conduct of the NMC; and (iv) what the Committee called "the practical reality of litigious life".

11. The NMC is not of course responsible for the conduct of the defence. However, the NMC is obviously responsible for its own conduct; and the complexity of the case and "the practical reality of litigious life" are matters which the NMC must shape its procedures to accommodate. When every allowance is made for the extent to which the conduct of the defence contributed to the delay, the length of time which these disciplinary proceedings took remains disgraceful.

The Result of the Disciplinary Proceedings

12. What then was the outcome of these inexcusably long proceedings?

13. At the start of the disciplinary hearing each registrant faced nine heads of charge, embracing (on my count) 116 particular allegations in the case of Sarah Johnson and 112 particular allegations in the case of Lynette Maggs. By the time of final submissions on the facts, two heads had been withdrawn and numerous particular allegations were no longer pursued. In its findings of fact, the Committee found only 22 particular allegations under four heads of charge proved against Sarah Johnson and 14 particular allegations under three heads proved against Lynette Maggs.

14. At the next stage of the procedure the Committee had to decide whether on the basis of the facts found proved the registrants were guilty of misconduct. The Committee decided that Sarah Johnson was guilty of misconduct in relation to nine particular allegations under two heads of charge and that Lynette Maggs was guilty of misconduct in relation to four particular allegations under one head.

15. The final stage of the procedure was for the Committee to decide what sanction to impose. Having considered "the circumstances particular to this case", including the length of the proceedings and the length of time which had elapsed since the relevant events had occurred, the detrimental impact of that length of time on the registrants, and their previously unblemished career histories and positive testimonials, the Committee decided to take no further action. At the end of this eight year case, therefore, no action was taken in relation to either registrant.

16. Thus had the mountains laboured and brought forth a mouse.

The Claim for Judicial Review

17. The registrants have nevertheless been left with findings of misconduct against them. As the Committee noted in its decision on sanction:

> "It is a serious matter to be found guilty of misconduct by the [NMC]'s professional conduct committee …"

Sarah Johnson has a previously unblemished career of 30 years spent caring for the elderly. She continues to work in the care sector and is obliged to declare a finding of misconduct against her on any job application or any application to become a registered person for a care home. Lynette Maggs is no longer working in the sector having retired after 42 years of nursing, but the finding of misconduct casts a pall over her long and otherwise distinguished and unblemished career.

18. Both registrants are aggrieved by the findings of misconduct and wish to challenge those findings. However, because the NMC decided to take no action against the registrants, they have no right of appeal. Under s.12 of the Nurses, Midwives and Health Visitors Act 1997, a right of appeal lies to the High Court only against a decision to remove or suspend a person's registration. The decisions in this case have not affected the registration of Sarah Johnson or Lynette Maggs. In these circumstances their only means of challenging the decisions to find them guilty of misconduct is by a claim for judicial review.

19. The grounds on which the court will interfere are accordingly narrower than would be the case on an appeal. In particular, it is not enough for the registrants to show that the decisions were wrong. In order to succeed they must show that the Committee acted unfairly or irrationally or otherwise unlawfully.

20. The present proceedings were begun on 8 March 2012. Permission to proceed was granted on 15 June 2012 by Ouseley J, who ordered that the two claims be heard together. The unsatisfactory waiting time for hearings in this court has involved yet further delay.

The Findings of Misconduct

21. The charge on which the Committee found that both Sarah Johnson and Lynette Maggs were guilty of misconduct was Charge 2. This alleged that the registrants

"failed to ensure that adequate nursing records were maintained" in respect of seven individual residents of the Home.

22. The particular allegations found proved related to four residents and were as follows:

i) In respect of Resident J, that "no risk assessment or care plan in relation to falls was kept during the period 12 May 1999 to 24 January 2002";

ii) In respect of Resident K, that "no separate risk assessment in relation to falls was kept during the period 8 January 2001 to 17 April 2001";

iii) In respect of Resident D, that "there was no review kept of risk of falls and implementation of a care plan to reduce the risk and/or injury for the period 30 October 1998 to 15 May 1999"; and

iv) In respect of Resident A, that "no care plan was kept in relation to falls covering the period 25 May 1999 to 29 August 2000".

23. The grounds on which the Committee decided that, on the basis of its factual findings, Lynette Maggs was guilty of misconduct were explained as follows:

> "The sphere within which Mrs Maggs was nursing at the time was the care of the elderly in Nursing Homes. Mrs Maggs should have ensured that her system for record keeping with falls actively and expressly included proactive measures, such as a care plan and an assessment of the risk of falling in each case. This would have addressed the risk to patients of falling, which, in the elderly has a high morbidity rate ...
>
> The Committee found that the number of falls that were happening to the residents in the Charges found proved were of concern. Mrs Maggs could not have foreseen that the safety of the residents was assured following a fall. The simplest of risk assessments could have been used to document that all appropriate investigations and actions had been taken to safeguard the well being of the residents. Mrs Maggs had at her disposal a documentary framework for assessing the risk of falling, formulating an appropriate individualised care plan and undertaking reviews of the risks to the residents during their period of residence in the

> Home. The Committee finds the absence of such documentation in the context of repeated, frequent falling episodes with injury demonstrated sufficiently serious as to amount to misconduct."

24. The Committee found Sarah Johnson guilty of misconduct on the ground that her responsibilities as Manager included a duty to ensure that Lynette Maggs as Matron was maintaining appropriate records, including falls assessments and care plans for residents who had had a number of falls; and that her failure to ensure that this was done in relation to Residents J, K, D and A amounted, when viewed collectively, to misconduct. The Committee said:

> "Ms Johnson, as Manager, held ultimate responsibility for the safety and well being of residents in the Home. She was responsible for data collection and any subsequent investigation into falls in the Home, a known risk in that sector at that time. She was required to submit specific information with regard to falls occurring in the Home to Head Office and for reviewing the Home's Accident Book. This, in itself, in the Committee's view indicates the seriousness with which falls were viewed in the Nursing Home at that time. An integral part of preventing possible falls was ensuring that relevant and appropriate documents such as individual assessments, care plans and written reviews were completed as part of her investigations arising from accidents. It was her remit to ensure that such actions were taken by the Matron to complete the more detailed and specific documentation than simply a progress and evaluation entry of the fall occurring.
>
> The Committee has concluded that, in this way, as Manager, Ms Johnson should have ensured that the Home's system for record keeping with falls was addressed so as to actively and expressly include proactive measures, such as a care plan and an assessment of the risk of falling in each case. This would have met the risk to patients of falling, which, in the elderly has a high morbidity rate ...
>
> Falls, and investigating them in a pro-active way by checking that risk assessment and care plans were in place, were an intrinsic and important part of her role as Manager. ...
>
> The Committee finds that Ms Johnson's proven failure in respect of her omission is sufficiently serious so as to amount to misconduct."

25. The Committee also found Sarah Johnson (but not Lynette Maggs) guilty of misconduct in relation to Charge 7. This charge alleged that the registrants "failed to ensure a safe system for the administration of medicines, more particularly, failed to ensure that medication was consumed by residents after it was dispensed." The Committee made findings of fact that medication was left in the rooms of five residents on "various and unknown dates" in the periods while they were in the Home and that, in relation to three of these residents, Sarah Johnson learnt of occasions when medication had been left in their rooms but did not inform Lynette Maggs. The Committee stated that:

> "... whilst Ms Johnson had no direct responsibility for the administration of medication within the Home, she had an overall responsibility for ensuring the system was a safe one. Where she had knowledge of any occasions where this system had broken down, she had a responsibility to pass this information on to Mrs Maggs, as the Matron, who was responsible for training and supervision of staff who were directly administering medication, so that she could take action to address this."

26. The Committee concluded that the failures of Sarah Johnson in this regard were again sufficiently serious to amount to misconduct.

The Registrant's Case

27. The registrants' primary case, as advanced on their behalf by Ms O'Rourke QC, is that, in finding them guilty of misconduct, the Committee made several errors of law. In particular Ms O'Rourke submits that the Committee:

i) failed to understand the correct test for misconduct and in particular that a breach of professional duty must be serious in order to amount to misconduct;

ii) failed to understand that the concept of vicarious liability is not applicable to allegations of professional misconduct and that personal culpability is required;

iii) failed to understand the test established by Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 – that the standard expected of a professional person is that of an ordinarily competent member of the profession and not any higher standard;

iv) failed to understand that conduct must be judged from the perspective of the time when the events occurred and without employing hindsight; and

v) ignored the fact that the burden of proof lay on the NMC to prove misconduct beyond reasonable doubt.

28. Ms O'Rourke QC further submits that the Committee's findings of misconduct were not justified by its findings of fact and/or that the reasons given for the findings were inadequate.

29. In addition, the registrants have advanced a secondary case that the findings of fact on which the findings of misconduct were based were perverse and completely contrary to the evidence. It is also argued, as a "subsidiary complaint", that the delays in the proceedings made the findings unfair.

The NMC's Case

30. On behalf of the NMC, Ms Lynn Griffin, in her admirably clear and focused submissions, disputes all these arguments. In particular, Ms Griffin submits that there is no evidence to support the contention that the Committee misunderstood the relevant law in any of the respects alleged. On the contrary it is apparent that the Committee was given correct legal advice and understood the advice given. Ms Griffin further submits that the Committee gave full and adequate reasons for its findings, and that the findings of misconduct made by the Committee were within the scope of reasonable conclusions that the Committee was entitled to reach.

31. In relation to all the relevant findings of fact made by the Committee, Ms Griffin submits that there was evidence to support the findings and that they cannot be described as perverse. She accepts that there was undue delay but submits that this did not prevent the Committee from fairly finding misconduct and was appropriately addressed by the decision to impose no sanction on the registrants even though misconduct had been found.

Alleged Errors of Law

32. I am unable to accept the registrants' primary case that the Committee failed to understand the relevant law. As well as submissions from counsel, the Committee received advice on the law from a Legal Assessor appointed by the NMC. This advice was given both orally and in writing. Before the advice was given, it was discussed and agreed by counsel for the registrants as well as counsel for the

NMC. No criticism is made of the legal advice given to the Committee; indeed, Ms O'Rourke accepts that it "could not be faulted." Moreover, the Committee expressly recorded in its decision in each case that it had accepted the Legal Assessor's advice. In addition, the Committee has set out accurately in the reasons given for its decisions the propositions of law which it is supposed to have misunderstood. This is an unpromising basis from which to submit that the Committee misunderstood the relevant law.

33. It is still no doubt in principle possible that the Committee could have forgotten or ignored the Legal Assessor's advice when it actually made its decisions; but there is nothing in the reasons given by the Committee which suggests that this happened. In fact, the reverse. Thus, in relation to each of the principles of law which the Committee is alleged to have misunderstood, passages can be found in the Committee's reasons in which the principle was expressly and demonstrably applied. For example:

i) In both cases the Committee expressly noted that misconduct must be "serious" and such as would be seen as "deplorable" by fellow practitioners. Furthermore, the Committee found that certain failures did not amount to misconduct because they did not satisfy this test. For example, under Charge 2, in addition to the matters which were held to be "sufficiently serious to amount to misconduct", the Committee declined to find that certain other "failures" by Lynette Maggs were "sufficiently serious" to do so.

ii) The Committee expressly approached the allegations against Sarah Johnson on the basis that she "could only have personally and professionally failed where she was aware of an issue and did not take appropriate action(s)." A little later in its reasons the Committee recorded its view that Sarah Johnson "was responsible for failures of others and of systems at the Home save and except where she could not reasonably have personal knowledge for events that had occurred or had failed to take place." While there are no corresponding statements in the case of Lynette Maggs, there is nothing to suggest that the Committee approached her case on any different basis. In each case various allegations were rejected because the Committee considered that the registrant did not know or did not have reason to know of the matter in question. Although there is some ambiguity as to whether the Committee regarded actual knowledge as necessary or thought constructive knowledge sufficient, it is clear that the Committee recognised that personal culpability was required for a finding of misconduct.

iii) The Committee expressly noted in its reasons that "the standard required of the professional is that of the reasonable average in terms of expertise,

skill and care." Certain allegations were rejected because they did not satisfy this test. For example, an allegation under Charge 2 that records ought to have been kept of pain suffered by Resident L was rejected on the ground that it was not in accordance with usual practice at the time to keep such records.

iv) The Committee likewise expressly noted "the principle that a professional must be judged at the time of the events in question and must not be judged by the wisdom of hindsight." Again, the Committee expressly applied this principle in rejecting various allegations – the allegation about the absence of pain records for Resident L again being one example.

v) The Committee expressly noted that the NMC bore the burden of proving the case and are doing so to the criminal standard of proof – i.e. beyond reasonable doubt. Various allegations were rejected because the Committee was not satisfied that relevant facts had been proved to this standard. For example, the Committee rejected an allegation under Charge 2 that a continence assessment ought to have been maintained for Resident I on the basis that "the NMC has not proved that these were necessary or a requirement at that time beyond reasonable doubt."

34. By contrast, Ms O'Rourke was unable to point to any passage in the Committee's reasons in which the Committee can be seen expressly to have applied an incorrect legal test.

35. Ultimately Ms O'Rourke's argument amounted to saying that the Committee must, despite all contrary appearances, have misunderstood the relevant law because the Committee reached conclusions which it would or could not have reached on a correct understanding of the law. On analysis, this is merely another way of asserting that the Committee came to a wrong decision when applying the law to the facts of the case. Such an argument is not a permissible ground of judicial review.

Adequacy of the NMC's Reasons

36. I also reject the registrants' contention that the reasons given by the Committee for its decisions were inadequate. Although there was no express requirement to give reasons contained in the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 which governed these disciplinary proceedings, in a disputed case where a person is charged with professional misconduct procedural fairness requires reasons to be given for any adverse finding. It is not necessary for such reasons to be elaborate. But they must be sufficient to enable the person

affected to understand what the tribunal concluded and why on the principal important controversial issues in the case.

37. It is important to distinguish the question of whether reasons are adequate to explain why the tribunal reached its conclusions from the question whether the reasons are adequate in the sense of providing a sufficient justification for the conclusions reached. One of the purposes of giving reasons is to enable the latter question to be determined so that an unlawful decision can be subject to effective judicial review.

38. In this case the Committee gave reasons for its findings which run to 48 (single spaced) pages in the case of Sarah Johnson and 44 pages in the case of Lynette Maggs. While length is of course not necessarily a measure of adequacy, it reflects the conscientiousness with which the Committee approached its task. Although they were not, and did not need to be, as detailed or analytical as a court judgment, I consider that the reasons given by the Committee met the purposes for which they were required. In particular the reasons given were adequate to explain the thought processes by which the Committee arrived at the findings which are material to the present claim and to enable the court to assess the reasonableness of those findings.

Alleged Irrationality and Perversity

39. This leaves the registrants' arguments that the findings of misconduct made by the Committee were irrational and that the findings of fact which formed the foundation for the findings of misconduct were perverse. It is convenient to consider these questions together, first in relation to the findings on Charge 2 and then in relation to the findings on Charge 7.

40. The test which must be met on a claim for judicial review before the court will interfere with findings of fact made by a tribunal is a high one. However, in seeking to characterise the Committee's factual findings as "perverse", Ms O'Rourke QC in my view set the bar even higher than the law requires. The term "perverse" has a connotation of wilful refusal to accept an obviously correct conclusion. Despite some dicta which use the language of perversity, however, it is clear that the grounds on which the court will review findings of fact are not as limited as this: see e.g. De Smith's Judicial Review (7th Edn) para 11-047. On matters of fact as in all matters involving an evaluative judgment, the standard of review is one of reasonableness. It is for the tribunal empowered with the task of finding the facts to evaluate the evidence and decide what weight to give it. But a tribunal is not exercising its powers lawfully if it makes a finding of fact which has no reasonable evidential basis. Thus, the court will intervene if the evidence is not reasonably capable of supporting the tribunal's finding or where the reasons

given by the tribunal do not rationally support the finding. It is also now an established ground of judicial review that a decision was based on a material mistake as to an established fact giving rise to unfairness: see E v Secretary of State for Home Department [2004] QB 1044.

41. It became apparent during the hearing that, in order to determine whether the findings of fact challenged by the registrants were reasonable, it was not sufficient for me to consider the passages in the evidence highlighted by each party, and I would need to look at all the evidence on which all the relevant factual findings of the Committee were based. I therefore asked counsel for the NMC to provide after the end of the hearing references to all the passages in the transcripts of evidence which support each relevant finding of fact made by the Committee so that I could be sure that I have reviewed all the evidence on which the Committee either expressly relied or could have relied in making those findings. I am grateful to Ms Griffin for performing this task and for extracting the relevant passages from 85 days of transcripts.

42. I proceed therefore to consider first the findings made in relation to Charge 2 on which both registrants were found guilty of misconduct, followed by the findings on Charge 7 which was found proved against Sarah Johnson alone.

Charge 2

43. As mentioned earlier, Charge 2 alleged that each registrant "failed to ensure that adequate nursing records were maintained" in respect of certain individual residents of the care home; and the particular allegations which the Committee found proved alleged failure to ensure that a risk assessment and/or care plan in relation to falls was maintained for four residents.

44. It is important to note that Charge 2 was an allegation about inadequate record keeping. Thus the charge was not that the registrants were guilty of misconduct in failing to ensure that in the case of certain residents the risk of falls was properly assessed and/or that appropriate action was taken to address the risk; it was that the registrants had failed to ensure that adequate records of these matters were maintained.

45. That charge would have been straightforward if the evidence had been that at the relevant time formal risk assessments and separate care plans for falls were standard records which any competent nurse in a care home was expected to complete (or update) as a matter of routine whenever a resident had a fall. That, however, was not the effect of the evidence heard by the Committee, nor did the Committee make any finding to that effect.

46. The NMC's case that the records referred to in the charge ought to have been kept was based not on any complaint but on the opinion of its expert witness, Marion Moody. In her evidence Marion Moody did not suggest that at the relevant time compiling a falls assessment or a care plan specifically for falls was a matter of routine record-keeping when a care home resident had a fall. The effect of her evidence was that, having reviewed the records of the residents at Lynde House (of whom there were some 400 in total during the period covered by the charge), she had identified four residents for whom, because of their individual circumstances including the number and frequency of their falls, a separate risk assessment and/or care plan for falls should have been prepared.

47. Ms O'Rourke argued that the Committee ought to have disregarded or discounted the evidence of Marion Moody, as she had never worked in a nursing home or in caring for the elderly and had no experience of what was normal practice at the relevant time. I do not accept this argument. No issue was raised at the disciplinary hearing regarding Marion Moody's qualification to give expert evidence; and the extent of her expertise and the weight which should be given to her opinions were matters for the Committee to assess.

48. It is, however, important to identify with some precision what the NMC's expert evidence was on this issue. On my reading of her evidence what Marion Moody was saying was that in the four cases that she had identified she believed as a matter of her clinical judgment that a separate falls risk assessments or care plan or both (as the case may be) should have been prepared. She did not go so far as to say that standards in care homes at the relevant time were such that any ordinarily competent and careful nurse was expected to prepare such documents for a resident who had particular characteristics. The reason why Marion Moody did not say this may well of course be that she was not able to do so on the basis of her experience.

49. The expert witness called by the registrants, Margaret Moody (no relation), had extensive experience of the practice in care homes at the relevant time. It was her evidence that during the period 1998 to 2001 to which the charge related written assessments of the risk of falls and separate care plans for falls were not normal practice in care homes. The gist of her evidence was that it was expected that all falls would be recorded along with the reasons for them and the action taken in consequence; a specific assessment of the risk of falls might also sometimes be recorded in the resident's notes, but this was a matter for the clinical judgment of the individual nurse responsible for the care of the particular resident.

50. The NMC's expert, Marion Moody, did not contradict this. Her view of the matter was, I think, encapsulated in the following statement (Day 37, page 122):

> "I think if you have a resident that is falling and one does

not need to do a risk assessment, I think that is a lack of good judgment."

The line between lack of good judgment and negligence in doing or not doing something can sometimes be narrow. The distinction is, however, of critical importance where – as here – it was necessary for the NMC to prove negligence in order for the charge against the registrants to get off the ground. It was necessary for the NMC to establish in the first place that it was negligent not to record in the resident's notes a risk assessment and/or care plan for falls (as the case may be) – the test for that purpose being whether any ordinarily competent member of the nursing profession exercising reasonable skill and care and applying the standards of the relevant time would have made such a record. Responsibility for the care of any individual resident, and for keeping that resident's notes, lay with an individual nurse. Only if it was negligent for the nurse responsible for a resident's care not to have kept a particular record did the further questions arise of (a) whether the Matron or Manager of the Home was negligent in failing to ensure that the record was kept and (b) if so, whether that negligence was so serious as to amount to misconduct.

51. For the reasons indicated, it does not seem to me that the evidence of Marion Moody on which Charge 2 was based was capable of supporting a finding that it was negligent for the nurse responsible for a resident's care not to have compiled a separate falls risk assessment or care plan for the resident. In these circumstances it is difficult to see how the Committee could reasonably have found this charge proved.

52. To reach a definite conclusion, however, I need to consider the specific factual findings made by the Committee in relation to each of the four residents in whose cases Lynette Maggs and Sarah Johnson were found to be at fault in failing to ensure that a separate risk assessment or care plan was kept, and to examine whether there was any evidence capable of supporting those findings. The four residents concerned were referred to (to preserve their anonymity) as Residents J, K, D and A.

53. Since Lynette Maggs had a direct responsibility for ensuring that care plans and other records were properly maintained for all residents in the Home, whereas Sarah Johnson did not, I will start by considering the Committee's findings on the charge against Lynette Maggs before considering the findings against Sarah Johnson.

Resident J

54. Resident J suffered from Parkinson's Disease. The Committee found that he fell approximately once a month from May to November 2000 and then from August 2001 to January 2002 – a total of 13 falls in this whole period.

55. The Committee found that Lynette Maggs ought to have ensured that a risk assessment and care plan were maintained for Resident J in relation to falls on the following grounds:

> "… the Committee noted that Marion Moody, the NMC's expert, had stated that there should have been a care plan and a risk assessment in this case. Moreover, the Committee noted that Margaret Jones, the Home's regional manager at the time, stated there should have been a risk assessment with "that many" falls as this resident had experienced. In addition, Mrs Maggs stated in evidence that she had wished she had made sure they had been done (in relation to all of the residents' falls risk assessment documentation). She also agreed in evidence in relation to Resident J that he was prone to falls, that she had missed an opportunity and that there should have been a care plan and risk assessment documentation. Thus the Committee finds this head of charge proved."

56. In my view, none of the evidence referred to by the Committee was reasonably capable of supporting this finding.

57. I have already referred to the evidence of Marion Moody, the NMC's expert, in general terms. Her evidence specifically in relation to Resident J (at Day 33, pages 18-19) was as follows:

> "A. I found no evidence that there was a care plan in place or that there was clear instruction to staff as to what they might have done to reduce the risk of falls. I also found no evidence there had been any analysis of the falls he previously had sustained with a view to trying to identify if there were any patterns which could then give some insight into whether or not at certain times of the day/night greater supervision was required.
>
> Q. Would that be undertaken in a risk of falls assessment?
>
> A. Yes, and it is an ongoing assessment as well. Each time

> the patient falls, what you are wanting to try and establish is could that have been prevented, and then you are beginning to build up a picture of the problems that are associated with that particular patient. Also, increasing falls could also be an indication that perhaps the patient's medication needed to be reviewed or that his dementia was worsening, because falls are often associated with patients with dementia."

58. Marion Moody therefore expressed an opinion that an analysis should have been done of falls which Resident J had sustained with a view to trying to identify possible causes and whether anything could be done to prevent them from recurring. However, Marion Moody did not say, either specifically in relation to Resident J or more generally, that any reasonably competent and careful Matron of a care home at the relevant time would have ensured that such an analysis was carried out. There is nothing in the evidence which indicates – or at least which provides any positive or clear indication – that Marion Moody was doing more than expressing her own clinical opinion about what she thought (at the time of giving evidence) should have been done in the case of this particular resident.

59. Margaret Jones, the Home's regional manager, gave evidence that Westminster Health Care, the owners of the Home, took the view that in some cases assessments of the risk of falls ought to be done and recorded in a resident's notes. However, it does not appear that she was asked to express or did express any view about whether a risk assessment should have been done in any particular case. Counsel for the NMC did not identify any passage in the transcripts in which Margaret Jones stated that there should have been a risk assessment with "that many" falls as Resident J had experienced – or in which Margaret Jones expressed any opinion about whether there should have been a risk assessment for falls in relation to Resident J (or any other resident). I therefore conclude that the Committee misstated her evidence in this regard.

60. The third matter on which the Committee relied is what it portrayed as admissions by Lynette Maggs that there should have been a care plan and risk assessment for falls in relation to Resident J. Regrettably, however, it again appears that the Committee has misrepresented the evidence. Lynette Maggs did state at one point that she wished she had made sure that separate assessments of the risk of falls had been done for all residents who were at risk of falling. That evidence (Day 47, page 58) was in the following terms:

> "… as I say, I think at that time we were using the Mobility Care Plan to put in anything about the mobility. I mean, on reflection now, looking back, I wish I had made sure that they were all done, but at that time that's what they were

doing and …"

It is plain that this was a regret expressed in hindsight and could not reasonably be regarded as an admission that she had been negligent judged by the standards and practice of the relevant time.

61. When asked specifically about Resident J, Lynette Maggs certainly agreed that he was prone to falls (because of his Parkinson's Disease) but she did not agree that "she had missed an opportunity and that there should have been a care plan and risk assessment documentation". In fact, her evidence was the exact opposite. The relevant passage (Day 47, page 49) reads as follows:

> "Q. Well Mrs Moody takes the view that there should have been a specific Care Plan; do you agree with that or not?
>
> A. I don't agree with her.
>
> Q. In effect what is said is that by failing to make the assessment that you missed an opportunity, potentially, to intervene to assist Resident J?
>
> A. Well, she didn't know Resident J; we did and we did our best for this gentleman. …"

62. Lynette Maggs went on to say that the practice at the time was to address falls in the care plan for mobility. The cross-examination continued (Day 47, page 50):

> "Q. The position of the NMC, through Mrs Moody, is that that was not sufficient; you understand that, that is the position Mrs Maggs, and you disagree with that?
>
> A. I think Mrs Moody made judgments on paperwork. She didn't know the patient and that in today's world she didn't seem to understand at that time and how much things have moved on in the last 10 years, which is great. But, you know, you've got to be judged, if you like at that time.
>
> Q. So, in terms of the question that I asked you, in the round you disagree with Mrs Moody for the reasons you have just told us?
>
> A. Yes."

63. The Committee's mistaken recollection that Lynette Maggs had admitted that there should have been a care plan and risk assessment for falls in relation to Resident J, when in fact her evidence was to completely the opposite effect, was clearly material to its finding that the charge had been proved. This in itself renders the Committee's finding unfair. In any event, the evidence actually given by Marion Moody, Margaret Jones and Lynette Maggs was not reasonably capable of supporting the Committee's findings. I conclude that no tribunal which had correctly remembered or reminded itself of the evidence could reasonably have reached the conclusion which the Committee did.

Resident K

64. The Committee found that Resident K had fallen on four occasions during the period of around three months that she was resident in the Home, including three falls in reasonably quick succession in January 2001. The Committee's reasons for finding that Lynette Maggs should have ensured that the nursing records for Resident K included a separate assessment of the risk of falling were as follows:

> "In relation to the alleged failure to maintain adequate nursing records, the Committee accepted the evidence of Ms Marion Moody, the NMC's expert nurse witness, that she had not seen a separate risk assessment in the record and that there should have been one, in light of Resident K's recent history of frequent falls (Day 34, page 58). Furthermore, Mrs Maggs also stated in her evidence that she wished she had made sure that a falls risk assessment had been done (Day 47, page 59). In addition, the Committee accepted the evidence of both of Mrs Margaret Jones, regional manager with the Group in 2001 and Ms Mawson, the registrant's registered nurse witness that there was a separate section in the residents' notes that could be used to assess risks, including the risk of falls. Whilst the Committee accepted the evidence of Ms Margaret Moody, the registrant's expert nurse witness, that such specialist risk assessment of falls was not routine in Care Homes at this time, and even taking into account that this matter is being viewed after the event, nevertheless, the Committee has accepted the evidence that the particular facts of this resident's propensity to fall at that time, using standards in Homes at that time, required a separate risk assessment of the risk of falling for Resident K, when it would have become apparent that she was liable to falls. The Committee finds that there was no such assessment in being."

65. The Committee thus accepted that specialist risk assessment of falls was not routine in care homes at the relevant time but nevertheless purported to accept "the evidence that the particular facts that this resident's propensity to falls at that time, using standards in Homes at that time, required a separate written assessment". The Committee did not identify any "particular facts of this resident's propensity to falls" or relevant "standards in Homes at that time" which led to that conclusion. Nor, so far as I have been shown, was there in fact any evidence to the effect stated by the Committee.

66. The sum total of Marion Moody's evidence in relation to Resident K was that she had not seen a separate risk assessment in the documentation (Day 34, page 58). Marion Moody did not even say in terms that there should have been one, though I take this suggestion to have been implicit. Again, however, it was at the very least unclear that Marion Moody was doing any more than to suggest what in her view would have been desirable. Certainly, Marion Moody made no claim that "standards in Homes at that time required a separate risk assessment".

67. The reference made by the Committee to the evidence of Lynette Maggs (which was a false reference) was presumably intended to identify the passage already mentioned in which Lynette Maggs stated that generally – and not in relation to the particular circumstances of Resident K or any other individual resident – she wished "on reflection now, looking back" that separate risk assessments had been done. Her evidence with regard to Resident K was that (as with Resident J) the risk of falls had been dealt with in the notes under the heading of mobility, as was the practice at that time. The following exchanges took place in cross-examination (Day 47, pages 73-74):

> "Q. So, in effect, the issue between you and Mrs Moody is a relatively small one in that she says there should have been a specific document where this assessment was made?
>
> A. I think that's where the difference is; that Mrs Moody is talking about the falls risk assessment, whereas we, if you like, put it under the umbrella of mobility and that is where the discrepancy has come.
>
> …
>
> Q. And in so far as she went, and she was not forceful about it, Mrs Moody said she felt that there should have been a risk assessment and there was not one on the notes.
>
> …

> A. Yes, because she had not looked at the mobility. As I said, she is looking at it from nursing today when there are these falls clinics and everything; whereas at that time it was just – I think it was probably just beginning to come out about the falls and setting up the falls clinics. So we did use mobility as the care plan …"

Nothing said by Lynette Maggs amounted to an admission of fault or otherwise provided any support for the Committee's findings.

68. The only other evidence referred to by the Committee was evidence from two witnesses that "there was a separate section in the resident's notes that could be used to assess risks, including the risk of falls". Self-evidently this provided no support for a finding that the standards expected of any ordinarily competent nurse or Matron in a care home at that time required a separate written assessment risk of falling to be recorded for Resident K.

69. Again, therefore, I conclude that the evidence was not reasonably capable of supporting the Committee's finding.

Resident D

70. The Committee found that Resident D had 14 falls in the period 30 October 1998 to 15 May 1999. The Committee noted that a risk assessment had been recorded concerning the danger of Resident D falling over the rug in her room, but this was not expanded to cover the risk of falling generally. The Committee also said that Mrs Maggs had admitted in her evidence that there was no care plan and that there should have been one. Again, no such admission was in fact made, although Lynette Maggs did say (Day 43, page 126) that she would have expected Sister Brigham, who was responsible for Resident D's care, to have assessed her risk of falling.

71. The Committee gave the following reasons for finding that Lynette Maggs had failed to ensure that adequate nursing records were maintained:

> "Mrs Marion Moody stated (Day 34, pages 76-77) that part of good practice (sic) 'if you are looking at the care to be provided under your managerial umbrella, is that you have some insight into what's gone on before. And particularly relevant is falls because it carries such a high morbidity rate. So I would not expect you to be pulling out all the files, but what I would jolly well expect is when I am

looking at the patient's records is to see the last review of the forms, the analysis. She then went on to describe the system in Homes of monitoring falls as a corporate organisation because of trying to reduce elderly people falling. The Committee noted that Ms Johnson, as Manager, was required to fill in a falls return to the WCG Headquarters each quarter which, in the Committee's opinion, supports the emphasis that Mrs Marion Moody had placed in her evidence on falls in Homes caring for the elderly at this time. The Committee noted that Mrs Margaret Moody stated that she did not think that at that time care plans for this situation were in place and that if there were other care plans, these would have been sufficient to monitor what was happening to Resident D and that 'an additional piece of paper wouldn't have stopped the fall necessarily' (Day 66, page 156). In addition, the Committee noted that Mrs Maggs stated in her evidence she felt the charge was 'unfair' as she was not working on that floor and that 'Marjory Brigham was the nurse in charge and the patient she knew very, very well' (Day 43, page 84). She also added in cross-examination about this matter, that the documentation in Resident D's records was sufficient to monitor the fall situation and that Mrs Marion Moody was 'coming from the world of the falls clinics now' (Day 47, page 90).

The Committee is of the view that the evidence overall supports the fact that falls in the elderly were a known risk in the Care Home sector at that time. In the opinion of the Committee this was evidenced by the requirement for a falls return to headquarters, the number of records, such as the Progress and Evaluation records of this resident, that referred to the fact of her falls, as well as the number of falls sustained by Resident D and that they were increasing in January to April 1999, at a time when her condition was very frail.

The Committee has concluded that on this matter, it found the evidence of Mrs Marion Moody, the NMC's expert, to be compelling and convincing and it preferred her evidence to that of Mrs Margaret Moody, the registrant's expert. It is clear to the Committee that this resident at this time was very ill and was falling more frequently. It is the Committee's conclusion that the expert evidence it has accepted in its own judgement points to a clear managerial duty of Mrs Maggs, as Matron, to ensure that adequate nursing records on the review of the risk of falls and the

> implementation of a care plan to reduce the risk of injury and/or to reduce the injury to Resident D were maintained. The Committee has concluded that these records were not maintained and that, therefore, for these reasons, she failed to fulfil this duty."

72. There seem to me to be two clear errors in this reasoning. The first is that it was a mistake for the Committee to regard itself as faced with a conflict between the evidence of the two Mrs Moodys and as having to decide whose evidence it preferred. There was in fact no such conflict. The NMC's expert, Marion Moody, did not contradict the evidence of the registrant's expert, Margaret Moody, that separate care plans for falls (where a resident was prone to falls) were not normal at the relevant time.

73. Marion Moody did say that it was "part and parcel of good practice" to ensure that the records of the "patient" (as she frequently referred to residents of a care home) included an analysis or "review" of the number of falls which that person had had and what was done about them. The suggestion that a "review" of this kind should have been kept – in addition to the accident book, which recorded details of all falls, and the quarterly returns, which reported falls during the quarter and the reasons for them – appears to have been made only in relation to this particular resident (Resident D). So far as I have seen, this is not a matter which was addressed by the registrants' expert, Margaret Moody. Nor, however, do I read the evidence of Marion Moody as going so far as to suggest that it would be not merely good practice to ensure, but negligent for a Matron in a care home at the relevant time not to ensure, that the records for a resident who had had a number of falls contained a "review" of the kind described.

74. The Committee also based its conclusion that Lynette Maggs was in breach of duty in part on a finding that "the evidence overall supports the fact that falls in the elderly were a known risk in the Care Home sector at that time". Here the Committee mistook what the issue was. The fact that falls in the elderly were a known risk in the care home sector at the time was not in question. It simply does not follow that because falls generally were treated as a matter of importance – as evidenced, for example, by the requirement to compile a falls return each quarter – therefore a separate "review" and care plan for falls were also records which it was standard at the time to maintain. It was fallacious for the Committee to reason, as it appears to have done, that because one type of record for falls was required, it was negligent not to ensure that a different type of record for falls was also kept.

75. Again, therefore, I consider that the evidence did not rationally support the Committee's finding.

Resident A

76. The Committee found that Resident A fell on 8 occasions between 25 May 1999 and 29 August 2000 and that there was no care plan for falls kept during this period. The Committee found that this constituted a failure by Lynette Maggs to maintain adequate nursing records again on the basis of the evidence given by the NMC's expert, Marion Moody.

77. The Committee's reasons were as follows:

> "The Committee has taken account of the number and severity of Resident A's falls and that the NMC's expert Mrs Marion Moody stated that this invoked a duty to develop a care plan in relation to falls. The Committee has accepted the evidence of Mrs Marion Moody (Day 35, pages 4-9) that there was a responsibility to provide such an audit by way of a care plan in circumstances such as this where the resident was falling regularly and where the resident would be at risk of falling again and causing himself further injury. Therefore, for these reason, the Committee finds this head of charge proved."

78. There were steps taken to address Resident A's falls which were documented in the nursing records, in particular using cot sides on his bed. The evidence of Lynette Maggs was that no more could reasonably have been done. All that Marion Moody said in evidence (Day 35, page 9) was that she found no care plan for falls and that she would expect to see one. She said nothing at all about whether separate care plans concerned specifically with falls were established or normal or even common practice at the time. I cannot accept that the bare statement of the NMC's expert that she would have expected to see a care plan was evidence on which a tribunal could fairly and reasonably find that no ordinarily competent Matron in a care home at that time would have failed to ensure that the nurse responsible for the care of Resident A had developed a care plan in relation to falls.

Misconduct

79. Even if, contrary to my view, there was evidence reasonably capable of being treated by the Committee as demonstrating that separate risk assessments and/or care plans for falls should have been compiled for some or all of Residents J, K, D and A, it required a further step to find that Lynette Maggs was guilty of misconduct. It was common ground, and the Committee accepted, that simple negligence was not sufficient for this purpose and that "gross professional

negligence" or conduct that would be seen as "deplorable" by fellow practitioners was required.

80. Even when every allowance is made for the fact that what amounts to misconduct is pre-eminently a matter for the judgment of the specialist tribunal, I do not consider that there was evidence in this case was reasonably capable of supporting such a finding.

Charge 2 - Sarah Johnson

81. The finding of misconduct made in relation to Sarah Johnson suffers from all the same defects as the finding made in relation the Lynette Maggs, but also from additional flaws.

82. The reasoning by which the Committee found that Sarah Johnson had failed to ensure that the nursing records for Residents J, K, D and A included risk assessments and care plans for falls involved two stages. The first stage was the Committee's finding that Lynette Maggs ought in each case to have ensured that such records were maintained. The second stage was to find that Sarah Johnson was at fault in failing to identify Mrs Maggs' omission.

83. The second stage of the Committee's reasoning was stated in identical terms (with one exception) for all four residents as follows:

> ".. Ms Johnson managerial role in this respect encompassed a quarterly return to WHC which included falls for which she was responsible for compiling. Therefore, the Committee has determined that Ms Johnson would have known the number of falls occurring at the Home. Furthermore, an accident book was kept by the home and she stated in evidence that she was responsible for reviewing it (Day 53, page 112). In the Committee's opinion, therefore, Ms Johnson had the information available that should have triggered an investigation to determine if the appropriate actions and records had been kept, including a general risk assessment form for [the resident]. The Committee took into account that Ms Johnson knew that there was a general risk assessment section in the WHC documentation that could be used to assess the risk of falls (Day 53, page 113)."

The exception is that in the case of Resident A no reference was made to a general

risk assessment form, as the allegation in that case was limited to the absence of a care plan rather than a risk assessment.

84. The Committee thus inferred that the fact that Sarah Johnson had information available to her showing that a resident had sustained a number of falls "should have triggered an investigation" to determine if a risk assessment form for falls had been completed. However, so far as I have seen and counsel for the NMC has identified, there was no evidence to support this conclusion. The NMC's expert, Marion Moody, did not assert that Sarah Johnson ought to have done this. Nor, so far as I have seen did any other witness. Sarah Johnson herself did not accept that her responsibilities included checking the completeness of records except by way of a random sample when audits were carried out.

85. Nor does the fact that the documentation for residents included a general risk assessment section that could be used to assess a risk of falls or any other risk provide any rational support for the NMC's case. The evidence of Sarah Johnson which the Committee "took into account" was as follows (Day 53, page 113):

> "Q. … was there any set documentation for care plans for falls, was there any guidance from Westminster in terms of policies for it?
>
> A. No. We had a general risk assessment form and the risk could be anything that we'd identified. I mean, if you were looking after somebody in their own home, it would be different because often you are looking at the environment and seeing where the environment is perhaps the reason for falls, whether they have got steps and that sort of thing. But in a purpose-built nursing home, all the rooms were the same, all the en suites were the same and we had the same grab rails and raised toilet seats, so …"

86. Sarah Johnson's evidence was therefore to the effect that, while there was a general risk assessment form that could be used for any identified risk, there was no reason to use it to assess the risk of falls in the environment of a nursing home. On any view, that evidence is not reasonably capable of supporting a finding that Sarah Johnson ought to have ensured that the documentation was being used to assess the risk of falls in the case of any resident who had a history of falling.

87. There is a further flaw in the way the Committee made this finding. So far as I have been shown, the allegations which the Committee found proved against Sarah Johnson were never put to her when she gave evidence at the fact finding stage of the hearing. Thus, no suggestion was made to her that separate risk

assessments and/or care plans for falls ought to have been prepared for any individual resident. Nor was it suggested that she ought to have checked the records of any individual resident to determine whether such documents had been prepared.

88. Sarah Johnson was asked to comment on those allegations on Day 83, but only after they had already been found proved by the Committee which was now proceeding to determine whether this failure amounted to misconduct. At that stage Sarah Johnson explained very clearly why she did not accept the Committee's findings. In particular she explained why she did not accept that a separate falls assessment or care plan would have been necessary or useful and also why she did not accept that it was in any event her responsibility to investigate the adequacy of the records. She also made the point that it was never suggested by any of the regional managers and others who audited the records of the Home that the records were deficient in that respect.

89. By the time this evidence was given, however, the Committee's findings of fact had already been made. To find the relevant facts proved before Sarah Johnson was questioned about the allegations was unfair.

Charge 2 - Conclusion

90. I conclude that the findings of misconduct made against Lynette Maggs and Sarah Johnson on Charge 2 were unreasonable, unfair and in consequence unlawful.

Charge 7

91. Charge 7 alleged that each registrant "failed to ensure a safe system for the administration of medicines, more particularly, failed to ensure that medication was consumed by residents after it was dispensed" and that "having failed to ensure a safe system for the administration of medicines, you are guilty of misconduct." Particular allegations were made that medication was left in the rooms of six residents on "various and unknown dates". (The allegation in respect of one of these residents was withdrawn on Day 34 of the hearing.)

92. The Committee found this charge not proved in relation to Lynette Maggs but proved in relation to Sarah Johnson. Since the Committee found that Lynette Maggs was directly responsible for ensuring that nurses operated a safe systems for the administration of medicines, whereas Sarah Johnson was not, the result reached by the Committee is at the very least a surprising one, albeit not logically impossible.

93. The system for administering medication was that medication prescribed to a resident was dispensed up to four times a day by a registered nurse and the nurses were instructed by the Matron, Lynette Maggs, to make sure that the medication was swallowed in their presence. It was not accepted practice to leave medication in a resident's room and nurses were not authorised to record that the medication had been dispensed unless they had seen it consumed. That said, Lynette Maggs and other witnesses pointed out the difficulties in a nursing home, where residents are independent adults entitled to make their own choices and to be treated with respect, of ensuring that medication is consumed in the nurse's presence when residents decline to do so and insist that it be left for them to take later.

94. The Committee made findings of fact that medication was left in the rooms of five residents on "various and unknown dates" between October 1998 and a later date – which ranged from July 1999 in the case of Resident D to 31 January 2002 in the case of Resident F. These findings were based on evidence given by relatives of the residents concerned that there were occasions when they had found unconsumed tablets or other medication in the resident's room when they came to visit.

95. The grounds on which the Committee found that Charge 7 had not been proved in the case of Lynette Maggs were, first, that the Committee found that she only had direct knowledge of one incident (relating to Resident Q) in which medication had been left in a resident's room and, second that:

> "the Committee was satisfied that the evidence demonstrated that Mrs Maggs had trained her staff and had ensured as best as she could, in the circumstances of the case, as Matron of the Home, that they knew how to administer the medication. In the Committee's opinion, the fact that there have been a number of incidents of medication being left in the residents' rooms is outweighed by the efforts demonstrated by Mrs Maggs in her evidence of how she had set up, and ensured were maintained, systems to ensure the safe administration of medicines. The Committee has concluded that Mrs Maggs has done all she could and could not reasonably have predicted the number of tablets left unconsumed by residents in their rooms, especially when the staff administering the medications were registered nurses, also with a duty to comply with the UKCC's Guidelines on the Administration of Medication and the relevant UKCC Code of Professional Conduct.
>
> For these reasons, the Committee has found that Mrs Maggs had not failed to ensure that medication was

> consumed by residents after it was dispensed and that, therefore, she had not failed to ensure a safe system for the administration of medicines. Thus head of charge 7 is found not proved."

96. By contrast, Charge 7 was found proved in relation to Sarah Johnson on the basis that, on the Committee's findings, Sarah Johnson had acquired knowledge of incidents involving medication being left in the rooms of three residents but had not informed Lynette Maggs. In particular, the Committee found that:

i) The daughter of Resident O had complained in a letter to Sarah Johnson of (among other matters) finding plastic pots of pink liquid in her mother's room which were likely to have been an antibiotic medicine; but Sarah Johnson had not addressed this issue in her reply.

ii) The daughter of Resident D (AW) had on "many occasions" seen pills in her mother's room and had mentioned this when she met Sarah Johnson (which she did three times).

iii) The daughter of Resident Q had found tablets in a pot and under the bed on occasions when she visited her mother and had spoken to Lynette Maggs and to Sarah Johnson about it.

97. On this basis, the Committee found that:

> "…Ms Johnson had direct knowledge of incidents involving medication being left in the rooms of three residents. … The Committee has also taken into account the fact that Ms Johnson had herself stated in evidence that she had seen medication (pills) on the floor (Day 54 page 136). Thus the Committee has concluded that Ms Johnson had considerably more direct knowledge of the problems with the medication not being fully administered than Lynette Maggs, although the Committee takes into account the fact that there were many drug rounds over approximately these three years with a total of 72 residents at maximum capacity at any one time.
>
> However, such was the level of intensity of this problem at this time and the level of contact that Ms Johnson had about this issue with the relevant relatives and friends of the residents concerned, especially Mrs W, that the Committee has concluded that when this happened there

> was not a safe system for the administration of medicines in place. In the Committee's view, Ms Johnson as Manager of the Home, had it in her power to inform Mrs Maggs immediately about the issues as she, Ms Johnson, heard about them, for Mrs Maggs to be aware of them and to address them. In the Committee's opinion Mrs Maggs believed that she had a safe system of medicines administration in place and, she could, relatively easily, have attempted to rectify any problems as they arose if she had known the full extent of these.

98. At the next stage of the procedure the Committee found that these failures by Sarah Johnson were sufficiently serious to amount to misconduct. In my view, the finding of misconduct fails the test of reasonableness for three reasons.

99. The first is that there was no evidence on which the Committee could fairly find – let alone applying the criminal standard of proof – that Sarah Johnson had "on various and unknown dates" between 10 and 13 years earlier failed to pass on to Lynette Maggs reports that medication had been found in the rooms of three residents. Not surprisingly so long after the relevant events, Sarah Johnson had no recollection of being informed of any of the alleged incidents. Assuming, however, that the Committee was entitled to find, despite the staleness of the evidence, that the relatives of the residents concerned had raised the matter with Sarah Johnson, I can see no reason to suppose – let alone find proved beyond reasonable doubt – that Sarah Johnson did not mention this to Lynette Maggs at the time. (In the case of one of the residents, Resident Q, the Committee in any event found that Lynette Maggs had herself been informed of the incident.)

100. So far as I can see from the transcripts, there was no evidence – from Sarah Johnson, Lynette Maggs or anyone else – that Sarah Johnson did not pass on any such information to Lynette Maggs. It does not appear that this suggestion was ever even put to or raised with Sarah Johnson in evidence at all. Lynette Maggs was asked a general question about whether Sarah Johnson ever discussed with her issues of residents not swallowing their medication, to which she replied (Day 83, page 106):

> "If we were concerned about anything, we would obviously discuss it, but it is such a long time ago now I can't remember. But if there were any concerns about somebody not taking their medication, we would have dealt with it."

In these circumstances there seems to me to have been no evidential basis for finding that Sarah Johnson failed to inform Lynette Maggs of any particular incident involving medication being left in the room of any resident.

101. I am also troubled by the statement that the Committee took into account "the fact that Ms Johnson had herself stated in evidence that she had seen medication (pills) on the floor." This is a reference to an acknowledgement by Sarah Johnson that she did on the odd occasion during the period (of some 5 years) when she was the Manager of the Home find a tablet on the floor "usually where the resident had spat it out or hadn't wanted to take it and that was unbeknown to the nurse" (Day 54 page 136). There is no reason to suppose – and it was not suggested – that Sarah Johnson did not point the matter out to the nurse on any such occasion. Nor is it even apparent that any such occasion occurred during the period of charge. To use this evidence against Sarah Johnson as indicating some culpable failure on her part in failing to ensure a safe system for the administration of medicines was palpably unfair.

102. The second flaw in the Committee's decision is that even if, contrary to my view, there was evidence capable of demonstrating that Sarah Johnson failed to inform Lynette Maggs of any particular occasion (on an unknown date over 10 years earlier) when medication was left in the room of any resident, I do not consider that such a finding was in any event capable of proving the charge.

103. As mentioned, the charge was that the registrants had "failed to ensure a safe system for the administration of medicines, more particularly, failed to ensure that medication was consumed by residents after it was dispensed." Both the wording of the charge and the Committee's findings elide failing to ensure a safe system for the administration of medicines with failing to ensure that medication was consumed by certain individual residents on certain particular occasions when it was dispensed. A nurse who failed to ensure that a resident consumed medication when it was dispensed had not complied with the system for administering medicines. However, it simply does not follow from the fact that the system was not complied with on a number of occasions that the system was unsafe – let alone that Sarah Johnson was at fault in failing to ensure that there was a safe system. To draw that conclusion it would be necessary to point to some defect in the system for the administration of medicines operated by Lynette Maggs and to identify some respect in which the system could and should have been improved. However, the Committee did not identify any defect in the system or suggest that there was any other, better system which ought to have been adopted. In those circumstances, the Committee's findings were, in my view, incapable of rationally supporting the conclusion that Sarah Johnson "failed to ensure a safe system for the administration of medicines" – which is the basis on which she was held to be guilty of misconduct.

104. The third reason why I consider that the Committee's decision was flawed is that, even if the charge had not depended on establishing that the system for administration of medication was unsafe, and even if (contrary to my view) the Committee's findings of fact were justified, I still do not see how those findings

could reasonably support a finding of professional misconduct. I am bound to say that the Committee appears at this point in the case to have lost a sense of perspective. The Committee's statement that "such was the level of intensity of this problem at this time and the level of contact that Ms Johnson had about this issue with the relevant relatives" implies that the matter had a prominence at the time for which there is no basis in the evidence. On the Committee's findings, Sarah Johnson was during a period of three years informed of a handful of occasions when medication had been found in a resident's room. That needs to be seen in the context that the Home had 72 residents at any given time and some 400 in total during the relevant period, most of whom were receiving medication up to 4 times a day. There were therefore hundreds of thousands of tablets dispensed during the period in question. The evidence simply did not support the notion that there was a systemic problem of failing to ensure that medication was consumed or one which reached any significant level of intensity.

105. As Manager of a Home with 72 residents and around 100 staff, Sarah Johnson had many responsibilities. If there were a few occasions when she failed to pass on to Lynette Maggs information that a resident had not consumed their medication, that would obviously be a matter of disappointment. To find misconduct, however, the Committee had been advised and had accepted that the failure had to be such as would be seen as "deplorable" by fellow practitioners and as involving a "serious departure from acceptable standards", and that gross professional negligence could fall into this category if it rose above the level required to give rise to civil liability. Making every allowance for the fact that the judgment was one for the Committee to make, the finding of misconduct made against Sarah Johnson on this charge was in my view so far out of proportion to the nature of the failure found that it is not one which the Committee could reasonably reach.

Conclusion

106. For the above reasons, I hold that the findings of misconduct made by the Professional Conduct Committee of the NMC against Sarah Johnson and Lynette Maggs were unlawful and must be quashed.

107. A decade after this misconceived and mismanaged case was brought against the registrants, their names are clear.