Neutral Citation Number: [2006] IEHC 226

THE HIGH COURT

[2006 No. 66 SP]

BETWEEN

CLIONA FINNEGAN

APPELLANT

AND
AN BORD ALTRANAIS

RESPONDENTS

Judgment of Mr. Justice McGovern delivered on the 28th day of July, 2006

1. This case involves an appeal against a decision of the Fitness to Practice Committee of An Bord Altranais made on the 2nd February, 2006, whereby the appellant was found to be guilty of professional misconduct. The appellant also appeals against the sanction imposed by the respondent namely that her name be erased from the Register of Nurses established under the Act. The appeal is brought pursuant to s. 39(3)(a)(i) of the Nurses Act, 1985. The appeal involved a complete rehearing of the matter in the High Court.

2. The appellant was a nurse employed at Stella Maris Nursing Home, Commer, Tuam, Co. Galway. She was employed on a part-time basis and it is alleged that on the night of the 14th August, running into the morning of the 15th August, 2002, she remained on duty when she was not in a fit condition to do so and thereby put patients at risk. The specific allegations against her are set out in a Notice of Intention to hold an inquiry dated 4th March, 2005. In that notice the following allegations were made against her:-

> 1. When you are a nurse employed at the Stella Maris Nursing Home, Commer, Tuam Co. Galway on the night of 14th August, 2002, and the morning of 15th August, 2002:
>
> (a) You remained on duty when you were unfit to do so and knew or ought to have known you were unfit.
>
> (b) You failed to administer medications to patients or record such administration in patients' records in a correct or timely manner.
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> (c) You failed to ensure that medications would be kept and maintained in an orderly way or that their use would be recorded properly or at all.
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> (d) You caused the drugs at the said nursing home to be in such disarray to render it difficult or impossible to determine whether or to what extend they had been administered to patients.
>
> (e) You rested or slept during part of the time you were on duty.
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> (f) You appeared intoxicated. You had a brown liquid or traces of a brown liquid around your mouth. You spoke in an incoherent manner. Your speech was slurred. You swayed from side to side. You were wholly or partly unaware of your surroundings.
>
> (g) You failed to provide any or any proper nursing care to your patients.
>
> (h) You failed to provide the carers on duty with you with any appropriate assistance, guidance or supervision.
>
> (i) You are suffering from a physical or mental disorder rendering you unfit to engage in the practice of nursing.
>
> (j) Any other matter disclosed by the evidence, "the nature which is hereinafter set out."

3. A hearing in respect of these allegations took place before the Fitness to Practice Committee on the 15th September, 2005 and 27th October, 2005. Following the said hearing the appellant was found guilty of item 1(a), (b), (c), (d), (e), (f), save for the words [you were wholly or partly unaware of your surroundings] (g) and (h).

4. The committee found that she was not suffering from a psychical or mental disability rendering her unfit to engage in the practice of nursing and there were no facts proved in respect of item no. 3 on the Notice of Inquiry.

5. The matter came before the High Court by way of a complete rehearing of the evidence. Evidence was given by a number of witnesses.

6. Ms. Teresa O'Neill said that she was a carer in Stella Maris Nursing Home. She described the nightly routine and said that the patients would always know who was on duty. There would be two carers and a nurse on duty at night time for forty patients. On the night of the 14th August, 2002, she was on duty with Ms. Bridget Murphy. One of the residents was looking for her tablets at a time when she should have already been given them by the nurse on duty who was the appellant. Ms. O'Neill asked the appellant for the tablets and when she brought them to the resident she was told that there was half a tablet missing but the appellant said that the resident had got all her tablets. The lady concerned was reassured. A male resident was later looking for his tablets and she went to the appellant about that and got the impression the appellant was getting annoyed as she was being approached for a second time. However this resident should have got his medication by then. The patients were told by the carers that they would be given their medication in their bedrooms instead of the day room as was the normal practice. She said that while she and Bridget Murphy were carrying out their other duties they heard a bell ring and went to answer. Nurse Finnegan was lying on the floor of a bedroom belonged to a married couple who were residents there. She was down on the floor at the end of the bed with her back to the bed. They put her on her feet and she didn't seem to know what had happened. She was crying a lot. Later they heard a bang and found the appellant at the office station on the floor. She was on her backside with her two hands behind her. They picked her up and put her on a chair and she was upset. She was given a cigarette and coffee. There was a tray of medication scattered on the floor. The carers picked up the medication. The witness described the appellant's voice as slurred and she was told she should get some sleep. They put her on a couch where she slept heavily and was checked every fifteen minutes or so. The witness noticed a strong smell off her breath and there was a brown stain around her lips. The appellant didn't provide any nursing care to the patients that night. The witness described how they were covering up for the appellant because they didn't want to get her into trouble but admitted they should have brought her to the attention of Nurse Maloney who was one of the two proprietors of the Nursing Home. She didn't know what the smell was. She described the appellant's voice as slurred. I found Ms. O'Neill to be a credible witness. Ms. Bridget Murphy

gave evidence which was broadly similar to that given by Ms. O'Neill although she didn't recall the male resident, referred to earlier, not getting his medication. She saw no drugs being administered by the appellant and said that if she had been administering them she would have seen her going about that duty. She describes at one stage finding the appellant on the floor with tablets all around her and that the tablets and medication were all mixed up. She didn't know what was wrong with her but got a smell off her but it wasn't a smell of drink. There was a brown mark around her mouth. The evidence of this witness was broadly consistent with that of Ms. O'Neill.

7. Nurse Teresa Maginnis gave evidence and described how she was the nurse due on the next shift after the appellant left in the early morning. She described ringing at the door and waiting some time and then the appellant let her in and walked away into the building. She asked the appellant for the key to the medicine room and was handed the key. She noticed a brown liquid stain around the appellant's mouth and down one side of her mouth. She didn't notice anything else about her at that stage. She then noticed all the drugs mixed up sitting on top of the medicine trolley and a brown liquid on the floor of the medicine room. She said that the mixing up of drugs in that fashion was dangerous and unacceptable as it wasn't possible to tell which medicine belonged to which resident or patient. At that time she went down and met one of the carers and asked was everything alright and was told things were not all right. When she asked the appellant to check out a scheduled drug with her she told her that she couldn't do it now she was busy. Such a drug would have to be checked out by two nurses. She described the response as unacceptable. She was so concerned about the situation that she phoned the proprietor Ms. Ann Maloney who told Nurse O'Donovan to go to the nursing home. Nurse O'Donovan lived nearby and Ms. Maloney arrived later. Nurse Maginns said that she had never had to deal with a situation like this before. I accept the evidence of Nurse Maginnis.

8. Nurse Breege O'Donovan gave evidence and said that she had been working in the nursing home for nine years and was a senior nurse on staff at the time. She described how she first met the appellant on 25th July, 2002, when she was on duty that night. She described her as a very pleasant girl and full of enthusiasm. She came across as being very confident and willing. The next time she saw her was on the night of the 14th August, 2002, when she was going off duty. She gave her the nurses' report. On the following morning she received a phoencall from Ms. Ann Maloney telling her there was a problem in the nursing home with the nurse on duty and would she go there as soon as possible. As she lived close by she went there and was met by Nurse Maginnis. She was told by Nurse Maginnis to go to the dining room. On reaching the dining room she found the appellant lying across the table with the nursing reports in front of her. The medications were all loose out on the table and her head was down. She described her as being slouched across the table and said she was a disgrace to the nursing profession. She wasn't orientated at all as to what she was doing. When she asked the appellant what had happened she replied "*nothing*" and started crying and then she sad she was fine. The medication was in disarray. She said that the appellant was steady on her feet when she brought her upstairs to a quiet room. She noticed brown liquid drooling from the side of her mouth and there was a kind of stale smell from her. She said that when Ms. Maloney came she asked the appellant what happened and offered to bring her home or to the Accident and Emergency Department of the local hospital and she also offered her a G.P. The appellant refused these offers. She felt the appellant was very lethargic. She said it took herself and another person four and a half hours to sort out the medication.

9. Nurse Ann Maloney who was a co-owner of the nursing home gave evidence. I found her to be somewhat evasive in her answers concerning the circumstances in which the appellant signed a note to say that she was travelling home by herself which was signed by 10.30 am on 15th August, 2002. Some of her answers were inconsistent with evidence she had apparently given to the Fitness to Practice Committee. These circumstances were mainly concerned with the events surrounding the departure of the appellant from the Nursing Home. I am satisfied however that she was telling the truth about what she found on her arrival at the Nursing Home on the 15th August, 2002, and that her evidence on this issue was corroborated by other witnesses. She described how there was little or no cooperation from the appellant when she sought an explanation for what had happened and she described how the appellant had refused to make eye contact with her. She also described a brown stain around the mouth of the appellant and said she was lethargic looking and sluggish. It appears that she may have phoned the gardaí to say that the appellant was drunk and that she also implied that the appellant had taken some medication. But her evidence on the issue as to the general condition of the appellant on the morning when she saw her and as to the surrounding circumstances was corroborated by other witnesses. Garda Maher gave evidence that the appellant called to the garda station in Galway to make a complaint that she was falsely imprisoned by the owner of the nursing home and that allegations had been made against her. But she left the garda station before a statement was taken. He did note that there was a strong smell from her and he had taken this down in his notes. He couldn't say for certain what it actually was.

10. The appellant gave evidence in the High Court although she did not do so in the Fitness to Practice hearing. I found the appellant to be vague and unconvincing as a witness. She remembered little or nothing about the night and at times she appeared quite detached from her surroundings. She offered no explanation for her behaviour.

11. Dr. Brian McCaffrey the psychiatrist gave evidence. He said the appellant wasn't able to give him a full account of her movements on the evening in question and that from about 1.30 am to at least half an hour before she woke up she was not fit to be on duty. She didn't seem to realise that she had fallen. He said there were a number of medical reasons why this might have happened but he didn't know for sure why it happened and he thought there might be some underlying medical cause. He agreed that the appellant seemed rather vague and that it was a serious matter to fill in the records for patients when she hadn't given them medication. Significantly he said that there was no reason why a nurse such as the appellant would not have been able to carry out the duties assigned to her that evening.

12. The appellant's mother gave evidence which was supportive of the appellant but she wasn't able to give evidence of assistance concerning the night in question at the nursing home.

13. I am satisfied from the evidence that the appellant was not in a fit or proper state to carry out her duties on the night of the 14th August, 2002 and the morning of the 15th August, 2002. I am quite satisfied on the evidence that the conduct of the appellant on that occasion fell seriously short of the standards of conduct to be expected among a member of the nursing profession. I also hold that her condition was such on the night and morning in question that it was conduct which could be described as 'disgraceful'. Undoubtedly her conduct seriously fell short of the accepted standards of the nursing profession. She offered no proper explanation to the court for her behaviour and was quite uncooperative with the other members of staff of the nursing home when they were trying to sort out the difficulties she had created. It was fortunate indeed that none of the residents suffered any adverse consequences from her behaviour and lack of proper nursing care. I therefore find the appellant guilty of professional misconduct.

14. It seems to me that the respondent imposed a proper sanction on the appellant in directing that her name should be erased from the register of nurses established under s. 27 of the Nurses Act, 1985. I reach this conclusion because of the nature of her behaviour and her failure to cooperate in the investigation and her failure to offer any explanation to the court for her conduct. Her conduct placed those who were in her care in danger. In my view the protection of the public requires that in the circumstances of this case the appellant should not be permitted to remain on the register. I would make the same findings on each of the charges set out in the

notice of inquiry as were made by the Fitness to Practice Committee.

15. In the circumstances I refuse the relief sought and I direct that the Board erase the appellant's name from the register.