ROYAL COLLEGE OF VETERINARY SURGEONS

INQUIRY RE:

MELANIE JANE HERDMAN RVN

COMMITTEE DECISION

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1. The respondent is a Registered Veterinary Nurse. She was not present, and was unrepresented, at the hearing.

2. The College was represented by Ms. Bruce, counsel, instructed by Capsticks, solicitors.

3. On the College's application, the Committee determined that the Notice of Inquiry had been properly served and that it was appropriate to proceed in the respondent's absence. The Committee's reasons for these decisions are set out at Annex 1.

4. The Committee also decided to receive oral evidence from a number of witnesses by video link. The Committee's reasons for these decisions are set out at Annex 2.

The Allegation

5. *THAT, being registered in the Register of Veterinary Nurses and whilst in practice at Galedin Veterinary Limited, Windmill Way West, Ramparts Business Park, Berwick Upon Tweed, TD15 1TB ("the practice"), you:*
   - *1. On or around 18 December 2020, indicated to Mrs. LC that you would supply the following for use by Mrs. LC's husband, Mr. WC:*
     - *(a) Diazepam; and/or*
     - *(b) Tramadol*
   - *2. On or around 19 December 2020 supplied to Mrs. LC and/or Mr. WC:*
     - *(a) Diazepam; and/or*

(b) Tramadol; and/or

(c) Gabapentin.

3. On or around 19 December 2020, provided advice to Mrs. LC regarding the dosages of Diazepam and/or Tramadol and/or Gabapentin to be taken by Mr. WC

AND that in relation to the matters set out above, whether individually or in any combination, you are guilty of disgraceful conduct in a professional respect.

6. Ms. Bruce referred the Committee to an email from the respondent, dated 17 July 2023, in which she wrote that she admitted the allegations at Charges 1 (a) and (b), the allegation at Charge 2 (a) and the allegation at Charge 3. She "strongly denied" the allegations at Charges 2 (b) and (c). Ms. Bruce made clear that the College intended in any event to present evidence in support of its case.

7. The Committee noted the contents of the email referred to by Ms. Bruce.

Background

8. The respondent was, at the time of the events referred to in the Allegation, employed as a registered veterinary nurse at the practice. She had been employed by the practice for some 17 years.

9. On 24 May 2021 Mrs. LC raised concerns with the practice manager in relation to controlled drugs which she said had been supplied to her by the respondent. In her email of that date, Mrs. LC wrote that in 2020 her husband, from whom she is now separated, had been experiencing a great deal of pain [redacted] and had been prescribed various pain-relieving drugs.

10. Mrs. LC alleged that during a conversation on 19 December 2020, conducted by way of a messaging app, she told the respondent, at that time a long-standing family friend with whom there had been some previous conversation about pain-relieving medication, that the medication which her husband was taking was not proving to be effective and that he needed something more than gabapentin and codeine. The respondent replied that she could provide diazepam and tramadol.

11. Mrs. LC alleged that the respondent supplied diazepam, tramadol and gabapentin to her for the use of her husband, and, further, advised as to what she considered to be appropriate dosages.

12. Following receipt of Mrs. LC's email, Mr. SD, the Practice Manager, discussed the concerns with others at the practice and an internal investigation was arranged. He also referred the matter to the College on 1 June 2021.

13. The internal investigation was carried out by Mr. CR, Deputy Practice Manager. He interviewed the respondent on 28 May 2021. During the course of this interview, the respondent admitted that she had supplied Diazepam only to Mr. WC. Following the conclusion of the internal investigation, Mr. CR reported the concerns to Northumbria police, though they subsequently took no action.

14. An internal disciplinary hearing was held at the practice on 7 and 8 June 2021, and this resulted in the dismissal of the respondent on grounds of gross misconduct.

Evidence

15. The Committee heard oral evidence from Mrs. LC; Mr. SD; Mr. CR; and Mr. PM, Senior Clinical Director at Galedin Veterinary Ltd who conducted the internal disciplinary proceedings.

16. The Committee was also provided with a bundle of documents which included the email in which Mrs. LC had raised her concerns, the records of interviews conducted by Mr. CR and Mr. PM, the practice's written policy in relation to the management of controlled drugs, clinical records relating to treatment given to the respondent's dog, a cocker spaniel called Rigby, and the respondent's written responses to the College in light of the concerns raised.

17. In her oral evidence given by way of video link, Mrs. LC confirmed the contents of her witness statement and exhibited the messages she had exchanged with the respondent on 19 December 2021. The relevant passages of text are as follows; Mrs. LC's messages are reproduced in bold, the respondent's (MH) in italics:

LC: "**I have a broken husband. I think he needs your special cocktail. I've given him gabapentin and codeine but he's needing the extra element….**

MH: *So what's he had and I will bring some other elements*

LC:**…. He's just had the gabapentin and codeine but he can't take nsaids. He's added in a beer to help it**

MH: I will bring some tramadol and diazepam he will be out for the count then it won't hurt!

LC: Tramadol not working anymore but diazepam will knock him out!!

MH: Works when you take it all together believe me!

And a little later in the exchange:

MH: *I left drugs for grumpy arse- forgot to say*

Max dose are

10 mg diazepam three times daily. Although start on 5 and see if he regains consciousness
Max 150 mg tramadol and 1200 mg gabapentin
Absolute cocktail of dreams."

18. Mrs. LC said that the respondent had left a package just inside her front door. The package included diazepam, tramadol and gabapentin. The diazepam was in an unlabelled box which she photographed. She exhibited the photographs. The tramadol and gabapentin were on separate "cards", and she regretted not having photographed them. She was sure that these three types of drugs had been delivered. In her initial email of 21 May 2021, she had referred to "Amatriptelene"(sic) as one of the drugs delivered but had corrected that in a subsequent email, of 24 May 2021, in which she substituted gabapentin for "Amatriptelene". She attributed that error to tiredness. [redacted] The respondent had given her no information about any possible side effects.

19. Mrs. LC said that she had taken the decision to report the matter to the Practice some five months after the event as she had come to reflect on the damage that could be done to a veterinary practice when the dispensing of controlled drugs was not properly managed. She was aware that she was not without fault as she had asked the respondent to supply her with drugs. She was also aware that her reporting of the episode might be regarded by some as an example of "sour grapes" or vindictiveness, as her husband was now in a relationship with the respondent. She told the Committee that she had asked the respondent to supply drugs because she had become desperate about the extent to which pain was impacting upon her husband's well-being. [redacted]

20. In answer to a question from the Committee in relation to a prescription which appeared to show that both gabapentin and tramadol had been properly prescribed to her husband by his GP, Mrs. LC initially said that her husband had not been prescribed gabapentin or tramadol at the time of the relevant conversation but subsequently corrected that answer on looking again at the text messages quoted above.

21. Mr. PM gave oral evidence by video link. He confirmed the contents of his witness statement and produced the record of the disciplinary interview he had conducted and an email he had written to the respondent in which he had confirmed that she was not accused of stealing drugs from the practice.

22. During the course of the disciplinary interview on 7 June 2021, the respondent admitted supplying diazepam but denied supplying any other drugs. She told PM that she had some

diazepam at home which had been prescribed for her dog but it had produced an adverse reaction in the animal, so she had not used all of the prescription. She accepted that her conduct in supplying the drug for the use of Mr. WC had been inappropriate and said that she had not thought about the implications. She denied using the drug herself and said that her knowledge of the drug's effects was derived from the fact that it had been used in treatment received by [redacted]

23. Mr. PM told the Committee that the drugs given to Mrs. LC were sedatives and could potentially be fatal. The respondent was not authorized to prescribe these drugs. He thought that the respondent assisted in stock-taking but the ultimate responsibility for the management of controlled drugs lay with the designated veterinary surgeon rather than with a veterinary nurse. On being referred to practice records relating to prescriptions for the respondent's dog, he said that the record seemed to show occasions on which the respondent appeared to prescribe for her dog. The record did not contain any reference to dosage and there was an absence of clinical notes by a veterinary surgeon to support the prescription or to identify the treatment which took place on the date given in the record.

24. Mr. SD, practice manager at Berwick, endorsed the contents of his witness statement and confirmed that the respondent had no authority to prescribe medication. In the course of the internal investigation, the practice's stock records had been examined. Mr. SD was referred by the Committee to the practice's policy document "*Management of Controlled Drugs Standard Operating Procedures*" and accepted that the policy had not been reviewed on the date set for review on the document (16/08/2020) but had been reviewed following the concerns raised by Mrs. LC. He said that staff were not required to sign a statement confirming that they were familiar with the document although the document would be provided on induction and was available on the practice portal.

25. Mr. SD said that the respondent dealt with weekly stock checks at the Berwick practice and had a responsibility to identify discrepancies. He accepted that the *Standard Operating Procedures* document did not state that the respondent had this responsibility. If discrepancies were identified, he would expect that matter to be reported to the Clinical Director who would investigate further. If the records showed that a number of discrepancies had been identified without investigation, he could only assume that the matter had not been reported.

26. Mr. SD told the Committee that he had considered it to be his responsibility to report the concerns related by Mrs. LC to the College before the conclusion of the disciplinary process as the concerns raised issues relating to a breach of trust on the part of the respondent.

27. Mr. CR, deputy practice manager at Berwick, confirmed the contents of his witness statement and exhibited the record of the interview he had conducted with the respondent on 28 May

2021. In that interview, the respondent stated that she had not supplied tramadol or gabapentin but admitted the supply of diazepam from a stock which she had at her home and which had previously been prescribed at the practice for her dog.

28. In his oral evidence Mr. CR stated that the clinical records relating to the respondent's dog did not show a prescription for diazepam, though he accepted that a veterinary surgeon within the practice, referred to by the respondent in relation to the prescription, had accepted that he might have trialled the use of the drug on Rigby.

29. The Committee also heard evidence from Mr. WC, who gave evidence via. video link. Mr. WC confirmed the contents of a witness statement he had provided on 4 February 2023. He said that, in December 2020, he had been prescribed both gabapentin and tramadol by his General Practitioner but that he was still in considerable pain [redacted] He understood that his wife and the respondent had discussed pain relief. He said that only diazepam had been supplied by the respondent as he already had prescriptions for the other two medications. He had not been present when the package containing medication had been delivered to his house. He said that he had only taken a single tablet of diazepam as he found that it had made no difference to his pain.

30. The Committee also had regard to written responses received from the respondent in relation to the allegations. In her response she maintained that she supplied diazepam tablets which she had had at home as a result of a prescription for her dog, Rigby. She wrote that she was trying to assist Mr. WC with the pain he was experiencing. She accepted that her actions in doing so "were irrational and completely irresponsible". The Committee has reminded itself that the respondent's account has not been given in evidence and has not been tested.

31. With the agreement of the College, the Committee also received a number of supportive testimonials which spoke of the regard in which the respondent was held by the writers. Ms. Bruce confirmed that there had been no previous regulatory findings against the respondent.

Findings of fact

32. The Committee received helpful oral submissions from Ms. Bruce and accepted the advice of the legal assessor. It recognised that the burden of proving each allegation rested upon the College and that it needed to be sure that an allegation was made out before finding it proved. The Committee considered each part of the Allegation separately but recognised that sub-paragraphs 2 (b) and (c) of Charge 2 raised essentially the same issue.

1. On or around 18 December 2020, indicated to Mrs. LC that you would supply the following for use by Mrs. LC's husband, Mr. WC:

(a) Diazepam; and/or

(b) Tramadol

33. The Committee had regard to the admission contained in the email to which Ms. Bruce had referred, and to the text of the messages quoted above, in particular, the words "*I will bring some tramadol and diazepam".* These words are a clear and unambiguous expression of an intention to supply tramadol and diazepam at the time they were written. The context of the conversation quoted above makes clear that this medication was intended for the use of Mr. WC.

34. The Committee therefore finds both limbs of Charge 1 **Proved.**

> *2. On or around 19 December 2020 supplied to Mrs. LC and/or Mr. WC:*
> *(a) Diazepam; and/or*
> *(b) Tramadol; and/or*
> *(c) Gabapentin.*

35. The Committee had regard to the admission in relation to the supply of diazepam contained in the email to which Ms. Bruce had referred and to the admissions in relation to diazepam contained in the interviews conducted at the practice, and in the respondent's written responses to the Allegation.

36. The Committee therefore finds Charge 2, sub-paragraph (a) **Proved**.

37. In relation to Charge 2, sub-paragraphs (b) and (c) the Committee noted that the respondent had consistently denied the supply of these drugs.

38. The Committee was satisfied that on 19 December 2020 Mr. WC was in receipt of prescriptions for both tramadol and gabapentin. That is the clear implication of the text messages quoted above, in which there are references to both drugs, and has been confirmed by the evidence of Mr. WC. The Committee has also seen a copy of a prescription for these drugs made out in favour of Mr. WC, although the prescription itself dates from 27 April 2021.

39. The Committee does not consider that the reference to an intention to supply tramadol, or the advice about dosages given in the last section of the messages quoted above, provide a safe foundation for a conclusion that the respondent actually supplied tramadol and gabapentin.

40. The Committee noted that the respondent was told by Mrs.LC that "**I've given him gabapentin**" and **"Tramadol not working anymore**". Mrs. LC also referred to her husband as needing "**the extra element**" in what seems to have been envisaged, by both parties to the conversation, as a cocktail of drugs. All of these references seem inconsistent with the respondent bringing more tramadol and gabapentin.

41. The Committee considers that the remark about leaving drugs and the advice about dosage in the last section of the relevant conversation is consistent with the respondent leaving a quantity of diazepam and being aware of what drugs Mr. WC was taking. It does not, in the Committee's judgment, point unequivocally to the respondent actually supplying each of the drugs to which she refers.

42. The Committee turned to consider the evidence of Mrs. LC who had said that all three types of drugs were supplied, the diazepam in a box and the tramadol and gabapentin on separate cards. The Committee noted that Mrs. LC had only produced photographs of the box containing diazepam and that her first report in relation to this episode was made five months after the event. The report was made at a time of very considerable personal stress. Her initial report contained an admitted error (which she later corrected) in that she had written that "Amatriptelene" (sic) had been supplied. She was also, in the Committee's judgment, mistaken in her oral evidence when she said, initially, that her husband had not been prescribed tramadol and gabapentin in December 2020.

43. The Committee has concluded that the evidence of Mrs. LC alone is not sufficient to discharge the burden which the College bears, having regard to, in particular, the terms of the contemporary conversation quoted above. In the light of that conversation and the matters referred to in the preceding paragraph, the Committee is not sure that the respondent actually supplied tramadol and/or gabapentin. In these circumstances the College has not discharged the burden of proof to the required standard.

44. Accordingly, the Committee finds Charge 2, sub-paragraphs (b) and (c) **Not Proved**.

> *3. On or around 19 December 2020, provided advice to Mrs. LC regarding the dosages of Diazepam and/or Tramadol and/or Gabapentin to be taken by Mr. WC*

45. The Committee had regard to the respondent's admission contained in the email to which Ms. Bruce referred and the final section of the conversation by text quoted above. The final section, beginning "*Max dose are*", is clearly advice about the dosage to be taken.

46. The Committee therefore finds Charge 3 **Proved.**

<u>Disgraceful conduct in a professional respect</u>

47. Ms. Bruce submitted that the respondent had been guilty of disgraceful conduct in a professional respect. She referred the Committee to the following provisions of the *Code of Professional Conduct for Veterinary Nurses* ("the Code"):

"1.5 Veterinary nurses who supply and administer medicines must do so responsibly;

6.5 Veterinary nurses must not engage in any activity or behaviour that would be likely to bring the profession into disrepute or undermine public confidence in the profession."

48. Ms. Bruce submitted that the respondent's actions had breached both of these paragraphs and had fallen far short of the behaviour expected of a member of the profession.

49. The Committee accepted the advice of the legal assessor, which included reference to the case of *Macleod v RCVS* [2005] PC 88.

50. The Committee accepted Ms. Bruce's submission that the paragraphs of the Code to which she had referred were engaged and that the respondent had breached both of those paragraphs. In the Committee's judgment there were a number of aggravating features of the respondent's conduct.

51. The respondent was not qualified or authorised to prescribe medication to animals, let alone to human beings. In providing a controlled drug to a person who was already taking various pain-killing medications she acted recklessly and put Mr. WC at risk of harm.

52. The medication which she provided had been obtained from the practice at which she worked to relieve pain which her dog had been experiencing. In giving this medication to Mrs. LC, for the use of Mr. WC, the respondent was guilty of a breach of trust and an abuse of her professional position. As the Code makes clear, veterinary nurses are expected to supply and administer medicines responsibly. Supplying a controlled drug to a friend is clearly a significant breach of professional responsibility.

53. The respondent herself has recognised that her actions fell far short of expected standards. In an undated written response to the College, following receipt of the witness statements which the College had obtained, she wrote "*I understand that the actions undertaken by me were irrational and completely irresponsible. They could have caused severe consequences for Will, as I did not have any training or authority to advise on the use of these drugs as I did".*

54. The Committee has concluded that the facts which it has found proved do amount to disgraceful conduct in a professional respect. In addition to the obvious risk to the health of Mr. WC, a reasonable and fully informed member of the public would be very concerned to learn that a veterinary nurse, in possession of a controlled drug obtained to relieve pain in her dog, had supplied that drug to a friend for his own use.

<u>Sanction</u>

55. Ms. Bruce confirmed that there were no previous regulatory findings against the respondent.

56. The Committee received an email from the respondent in response to the findings which the Committee had made. The respondent wrote that she accepted the findings and apologised for her actions which, she accepted, did not meet the standards expected of a registered veterinary nurse. She acknowledged that she had made "*a massive error in judgment in trying to help a friend in pain".* She assured the Committee that she had reflected deeply on her actions and that there would never be any repetition of this behaviour.

57. The Committee accepted the advice of the legal assessor.

58. The Committee recognised that it had identified what it considered to be the aggravating features of the respondent's conduct when deciding whether the matters which it had found proved amounted to disgraceful conduct in a professional respect. No useful purpose would be served by repeating these features here.

59. The Committee therefore turned its attention to mitigating factors. There were a number of factors which the Committee considered to be relevant.

60. The Committee accepted that the respondent's motivation arose out of concern for the health of a close friend. Her behaviour was a misguided attempt to alleviate the pain that he was experiencing. She engaged in that behaviour at the request of Mrs. LC, who told her that Mr. WC needed more pain relief than he was receiving and requested her to provide it.

61. The Committee also accepted that this was a single, isolated incident in a long career which was otherwise unblemished.

62. The Committee gave careful consideration to the email from the respondent it had received in relation to this stage of the proceedings, together with the respondent's earlier written responses. It was satisfied that the respondent had reflected carefully in relation to this episode and that there was no real risk of any repetition. The Committee noted that the respondent had been consistent in admitting fully to the supply of diazepam once the regulatory concern had been raised by Galedin Veterinary Practice and had not sought in any way to minimize her involvement or to deflect blame.

63. A significant period of two and a half years had elapsed since this episode and there had been no other reported concerns.

64. The Committee also gave very careful consideration to the testimonials submitted. A number were from professional colleagues who had worked with the respondent over long periods of time. An example is taken from the testimonial written by Mrs. HB. Mrs. HB writes that she

had known the respondent since 2005 when the respondent began to train as a veterinary nurse. HB worked at the Galedin Veterinary Practice. She writes:
In the time that I worked with Mel she developed into an exceptionally hard working nurse with excellent clinical skills and was developing as a leader in the team. She would put herself forward to do any tasks that were needed and would go above and beyond to help anyone. I found Mel to be trustworthy and honest and would continue to trust her. I believe this event was a one off due to her genuine desire to help others and she has learned from this. It would be tragic to lose such an exceptional nurse".

65. The second of the quoted paragraphs is in the Committee's judgment particularly important.

66. Drawing all of this material together, and considering the matter as a whole, the Committee has to impose a proportionate sanction for an isolated incident of disgraceful conduct in a professional respect which arose out of a misguided attempt to help a friend in pain. The conduct in question was entirely out of keeping with the respondent's usual practice and there is no real risk that it will be repeated.

67. The Committee considered sanction in ascending order. The case was much too serious to take no further action and no useful purpose would be served by postponing sanction.

68. The Committee also considered that a warning or reprimand would not be sufficient to satisfy the public interest. Veterinary nurses were trusted by the public to deal with medication responsibly and failure to do so was in every case likely to be a serious matter. It was certainly so in this particular case. The Committee did not consider that a warning or reprimand would be a sufficient response to the misconduct in question.

69. The Committee next turned to consider a suspension order. The Committee noted in particular, the content of paragraph 71 of the *Sanctions Guidance* which states:
Suspension may be appropriate where some or all of the following apply:
a) The misconduct is serious, but a lesser sanction is inappropriate and the conduct in question falls short of being fundamentally incompatible with remaining on the register;
b) The respondent… has insight into the seriousness of the misconduct and there is no significant risk of repeat behaviour;
c) The respondent is fit to return to practice (after the period of suspension)

70. In the Committee's judgment all of these factors are present in this case and the Committee considers that a period of suspension is sufficient to meet the public interest in maintaining the reputation of the profession and declaring and upholding proper standards of conduct for members of the profession.

71. In accordance with its usual practice, the Committee also considered whether a removal order would be appropriate. The Committee concluded that such a step would be disproportionate in view of all the factors outlined at paragraphs 60-66. Further, such a step would remove from the profession an experienced, competent and valuable veterinary nurse for no discernible benefit.

72. The Committee moved on to consider the appropriate period of suspension. It is satisfied that a period of three months is sufficient in the circumstances of this particular case to satisfy the public interest. That is a period which is sufficient to mark the gravity of the misconduct while taking into account the circumstances in which it arose.

73. The Committee therefore directs that the respondent's registration is suspended for a period of three months.

Disciplinary Committee
3 August 2023