Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 13 May 2024 – Friday 24 May 2024
Wednesday 22 October 2024 – Tuesday 29 October 2024

Virtual Hearing

Name of Registrant:	Rasheedat Suleiman-Reuben
NMC PIN:	01B1226E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (19 March 2004)
Relevant Location:	London
Type of case:	Lack of competence / Misconduct
Panel members:	Pamela Johal (Chair, Lay member) Lisa Holcroft (Registrant member) Tim Ward (Lay member) **(13 May 2024 – 24 May 2024)** Susan Ellerby (Lay member) **(22 October 2024 – 29 October 2024)**
Legal Assessor:	Christopher Mckay **(13 May 2024 – 24 May 2024)** Charlene Bernard **(22 October 2024 – 29 October 2024)**
Hearings Coordinator:	Hazel Ahmet
Nursing and Midwifery Council:	Represented by Christopher Harper **(13 May 2024 – 24 May 2024)** Michael Smalley **(22 October 2024 – 29 October 2024)**
Ms Suleiman-Reuben:	Present and represented by Dr Abbey Akinoshun
Facts proved:	Charges 3, 4a, 4b, 5 (proved by way of admission), 6, 7, 8, 10, 11, 13, 14, 15a, 15b, 16,

	17, 18.
Facts not proved:	Charges 1, 2, 9, 12, 19, 20a, 20b.
Fitness to practise:	Impaired
Sanction:	**Suspension Order (6 months)**
Interim order:	**Interim Suspension Order (18 months)**

Details of charge

‘You, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that:

1. On a date prior to 8 March 2020 spoke unprofessionally to Colleague A in that you:
    a. Raised your voice;
    b. Explained you would not feed a patient because you are a nurse, or words to that effect.

2. On a date prior to 9 March 2020:
    a. Did not change your apron or gloves between making beds;
    b. Did not work collaboratively with colleagues to wash a patient;
    c. Did not recognise signs of deterioration in a patient.

3. On 17 March 2020 failed to complete neurological assessments accurately or in a timely manner

While on a formal performance management action plan after 7 August 2020

4. On or about 3 November 2020:
    a. Did not communicate effectively with Patient A;
    b. failed to manage Patient A’s self- discharge adequately or at all.

5. On a date prior to 9 November 2020, discussed the details of an unknown patient with Patient B’s next of kin.

6. On a date prior to 11 November 2020 refused to help Patient C.

7. On 4 December 2020 administered an incorrect volume of feed to a patient.

8. On 5 December 2020 incorrectly administered Enaxoparin to a patient.

9. On a date between 8 February 2021 and 14 March 2021 refused to assist Colleague B to record a patient's observations electronically.

10. On a date between 8 February 2021 and 14 March 2021 behaved unprofessionally towards Colleague B by saying words to the effect of "have you done this before or not."

11. On a date between 8 February 2021 and 14 March 2021 administered an injection using only one hand instead of two.

12. On a date between 8 February 2021 and 14 March 2021 instructed a student nurse to hoist a patient without a second person to assist.

13. On 13 February 2021 failed to ensure that a patient was supplied, adequately or at all, with the means to carry out intermittent self-cauterisation.

14. On 16 February 2021 failed to administer Nimodipine to a patient.

15. On 17 February 2021 during a handover:
    a. spoke unprofessionally to colleagues during a handover;
    b. did not provide handover information in a structured manner.

16. On 15 March 2021 administered Gentamicin to a patient without clinical reason.

17. On or about 15 March 2021 behaved unprofessionally towards Colleague C by shouting.

18. On an unknown date in March 2021, unnecessarily interrupted handover involving a patient receiving Nimodipine.

19. On one or more occasions on dates unknown avoided answering nurse bells without justification.

That you, a registered nurse:

20. On an unknown date in March 2021 behaved unprofessionally by:
    a. shouting at colleague D;
    b. using words to the effect of “are you all fucking stupid. Can you hurry right now because I am going to bay one, bye”

And in light of the above your fitness to practise is impaired by reason of your lack of competence in respect of charges 1 -19 and/or your misconduct in respect of charge 20.’

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Harper, on behalf of the Nursing and Midwifery Council (‘NMC’), to amend the wording of charge 13.

The proposed amendment was to amend the word ‘cauterisation’ to ‘catheterisation’. It was submitted by Mr Harper that this word was simply an error in spelling, and he proposed that the amendment would provide clarity and more accurately reflect the evidence.

Charge 13 currently reads as follows:

‘That you, a registered nurse:

On 13 February 2021 failed to ensure that a patient was supplied, adequately or at all, with the means to carry out intermittent self~~-cauterisation~~.’

And in light of the above, your fitness to practise is impaired by reason of your misconduct.'

Charge 13 in its amended form will now read as follows:

'That you, a registered nurse:

On 13 February 2021 failed to ensure that a patient was supplied, adequately or at all, with the means to carry out intermittent self-catheterisation.'

The panel heard submissions from Dr Akinoshun, on your behalf, in which he agreed to the amendment to Charge 13, for the sake of clarity and correctness.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you, and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Harper under Rule 31 to allow the written statement of Colleague A into evidence. Colleague A was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today, as, all emails which have been sent to Colleague A, have failed to send, with no response from her.

Mr Harper submitted that, despite numerous attempts, the NMC had not been able to obtain a signed, written statement from Witness 1. Mr Harper submitted that the evidence is highly relevant and though not provided during the course of the NMC's investigation, was produced for the purpose of the internal investigations.

Dr Akinoshun submitted that, to allow the hearsay testimony of Colleague A into evidence would not be appropriate, as this would stand as the sole and decisive evidence for Charges 1a, 1b, 2a, 2b and 2c, and therefore, to admit it would be unfair. Dr Akinoshun highlighted that Colleague A is not incredibly familiar with you and is not present currently in this hearing; therefore, unable to be cross examined.

Dr Akinoshun submitted that you disagree with the submission made by the NMC and submitted that the hearsay testimony of Colleague A should not be allowed into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel was of the view that the hearsay testimony of Colleague A would stand as the sole and decisive evidence for Charges 1a, 1b, 2a, 2b and 2c, and therefore, to admit this as evidence would be disproportionate and unfair.

In these circumstances the panel refused the application.

Decision and reasons on application of no case to answer

The panel considered an application from Dr Akinoshun that there is no case to answer in respect of Charge 1a, 1b, 2a, 2b, 2c and 9. This application was made under Rule 24(7).

In relation to this application, Dr Akinoshun submitted that there is no realistic prospect in proving the allegations in Charge 1a, 1b, 2a, 2b, and 2c. He submitted that it is not in the public interest to pursue charges if there is no evidence before the panel to prove the facts. Dr Akinoshun submitted that all of these charges rely on the evidence of Colleague A, who did not attend the hearing. He highlighted that the hearsay application made by the NMC to rely on the statement of Colleague A's hearsay evidence, was rejected by the panel.

Consequently, Dr Akinoshun submitted that Charges 1a, 1b, 2a, 2b and 2c should not be allowed to remain before the panel.

In relation to Charge 9, Dr Akinoshun submitted that this charge is denied by you. He submitted that it has become apparent that this charge was 'made up' on an incorrect basis due to the following reasons; he submitted that you made the decision not to allow Colleague B to record on the logging system, as this was in conformity with the data protection and confidentiality policy of the University College Hospital NHS Foundation Trust. Dr Akinoshun referenced page 108 of the Exhibit Bundle, which sets out the Trust's policy, and makes clear that Ms you had complied with the policy in this instance.

Dr Akinoshun submitted that you had supported Colleague B in recording the patient's observation electronically by asking her to write the patients vitals on a piece of paper with the resident's information. This information would then be inserted into the Epiq System herself. By doing so, Dr Akinoshun submitted that you had ensured that there will be no breach in the Trust's policy on data protection and confidentiality.

Mr Harper submitted that the no case to answer application on Charges 1a, 1b, 2a, 2b, 2c and 9, are not resisted by the NMC; therefore, all such charges can be agreed to fail.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel had regard to the NMC guidance, [DMA-6] when deliberating on whether or not there is no case to answer in relation to Charges 1, 2, and 9.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of Charge 1 and Charge 2 proved as the proposed hearsay evidence which would have related to such charges, was the sole and decisive evidence, and was dismissed.

In relation to Charge 9, the panel found that there is no case to answer as it accepts that you were acting in accordance with the policy of the Trust.

Background

'The NMC received a referral concerning your fitness to practise on 8 July 2021 from [Person A], Senior Matron, University College London Hospitals NHS Foundation Trust ("the Trust"), your former employer.

At the time of the concerns raised in the referrals, you were a Band 5 staff nurse on the Ward, National Hospital for Neurology and Neurosurgery London ("NHNN"), part of the Trust.

Your name was first entered onto the NMC register in 1997. You commenced your employment at the Trust in 2005.

The alleged facts are as follows: On 30 May 2018, you are said to have knowingly administered 5mg of Oxycodone instead of 0.5mg whilst you were on an informal

performance management plan for two other drug errors and other competency related concerns. In March 2019, you were dismissed by the Trust. You were reinstated to your position on 2 November 2019, following a successful appeal, and you were transferred to another department on another site. In February 2020, you began working on the Ward at the NHNN.

In March 2020, the Ward Sister, [Witness 1], began to receive reports of concerns from staff on the Ward regarding your conduct and communication skills. As a result of these and other competency concerns, such as failing to pass neurological competency assessments, in April 2020 you were placed on an informal management plan. In July 2020, three patients complained of your treatment of them. In August 2020, you were moved on to a formal performance plan as you were considered not to be meeting the standards expected from a nurse.

Whilst on the performance plan, there were a number of further incidents where you were said not to have communicated with or treated staff and patients with kindness, respect and compassion, including concerns raised by a student nurse and other staff regarding how you were speaking to and treating them.

In November 2020, you were said to have demonstrated poor communication/empathy skills with a patient causing them to self-discharge, and to have communicated the wrong patient's details to a patient's next of kin.

There were also ongoing incidents and general concerns relating to your ability to demonstrate the standards of knowledge, skill and judgement expected from a nurse, including:

- *incidents of incorrect doses of medication and of prescribed food being given to patients*
- *on 13 February 2021, failing to supply a patient with catheters to self-catheterise after being informed you needed to do this task. After the patient ran out of*

catheters, you obtained and gave the patient the wrong size catheters and failed to communicate how to use the larger size

- *on 16 February 2021, failing to administer prescribed Nimodipine to a patient or check the treatment plan with the doctor and your communication was inappropriate during handover*
- *on 17 February 2021, inappropriate handover communications.'*

NMC Closing Submissions

'These submissions should be read in conjunction with the NMC evidence matrix. The written evidence of witnesses has not been quoted at length in these submissions, but the Panel are invited to refer to it in reaching decisions on the facts.

1. The burden of proof remains on the NMC throughout, to the civil standard, that is whether it is more likely than not that the allegation happened.

Case Chronology

2. A shorthand note used to address the Panel in opening is reproduced for assistance as follows:

Informal process in this case began after a meeting on 3 April 2020 (after charge 3)- [Witness 1] para 28-29

First action plan followed from 27 April 2020- [Witness 1]
Mid-point meeting 20 June 2020 (p136)

31 July 2020- p161 "argumentative" and "does not even understand why she is on an action plan in the first place"

Reviewed on 7 August 2020. Failed to meet the objectives so moved to the

formal process- [Witness 1] para 34-36
New action plan p162

RSR challenged the level of support and the standard expected on her. [Witness 1] pointed out she had had more support than normal.

At a review on 24 September 2020 (must be a typo at para 40 heading) she was given a formal warning after three patient complaints were discussed.
Reg again said she felt everyone was watching her and colleagues embarrassed her by questioning her on shift.

30 November 2020- stage 1 performance management action plan (p179).
Undated stage 2 follows

Second performance review on 11 Feb 2021 (part way through period for charge 9-12 and before 13 onwards). Still underperforming. [Witness 1] wanted to move to Stage 3 of the process but RSR refused to engage further.
Scored 2 in areas requiring 4 or 5 (p205)

HR involved. RSR said [Witness 1] insufficiently senior to oversee the review.

26 Feb 2021- formally moved to Stage 3 because level of competence still too low and multiple additional incidents

Final formal performance review in May 2021 at which she resigned.

General Submissions

3. The breadth of the charges in this case appears to have developed from initial difficulties passing the neurological observations assessment. Arising from that process, and the performance management that followed, are a series of

communication and inter-personal failings that make up a number of the charges.

4. Questions of whether Ms Suleiman-Reuben lacked competence are for the next stage of these proceedings and should not be brought into the fact-finding process. Equally, analysis of how any failings may have arisen, are relevant to impairment and not to this stage. For that reason, submissions will not focus on these questions at this point beyond some generally observations.

5. Throughout questioning of the NMC witnesses it has been variously suggested that Ms Suleiman-Reuben was under-supported, was not told of concerns about her behaviour such that she could learn from them, or was over-assessed and under respected in terms of her general nursing ability. Finally, the suggestion has been put to some witnesses that they should have intervened earlier to prevent faults arising.

6. To some extent there is tension in the lines of argument pursued on Ms Suleiman-Reuben's behalf. She simultaneously complains that she was not given the help she needed in a new area, and challenges why staff in the department failed to respect her years as a nurse and allow her to practise her way.

7. She questions why matters were not brough to her attention on the shift where they arose. It is noted that all but one of the allegations in this case are denied, which sits uncomfortably with the suggestion that other staff are at fault for not highlighting these issues.

8. Similarly, witnesses have been asked what they did to prevent things going wrong. The implicit suggestion is that they allowed Ms Suleiman-Reuben to fail for some reason.

9. That line of questioning is flawed in several respects.
i. Other nurses had their own caseloads to work on. For those who acted as nurse-in-charge on shifts Ms Suleiman-Reuben was on, they had extra supervisory responsibilities on top of very stressful jobs. They were entitled to

expect that she would manage a caseload proactively and work as a competent nurse.

ii. Ms Suleiman-Reuben bears the responsibility of asking for help if there were systemic issues preventing her from completing tasks.
iii. Ms Suleiman-Reuben, apparently continually, had a lighter workload than was normal which should have made it easier- not harder- to complete the work she was allocated to a suitable standard.

10. The witnesses universally report that Ms Suleiman-Reuben was reluctant to receive feedback or constructive criticism. They give evidence of her being unapproachable and hostile to any challenge to how she conducted herself. In those circumstances it is not surprising that matters were escalated through other routes. It is notable that the feedback did reach her for her to learn from it through the informal and formal processes, albeit each incident was not brought to her attention immediately.

11. Even among senior members of staff there is an apparent reluctance to challenge her or to bring issues to her attention for fear of the response they will be exposed to. The overall impression the Panel may feel it is left with is one of a team at a loss as to how to solve the difficulties she was experiencing. That stands in contrast to the allegations of persecution, and even conspiracy, advanced on her behalf.

12. The witnesses have been challenged on why issues were not brought to Ms Suleiman Reuben's attention when they arose, but her responses throughout the performance management process appear to have demanded greater respect for her experience. Staff were thus required to walk a tightrope to avoid offending against Ms Suleiman Reuben's contrasting complaints.

13. Further, it is notable that she benefitted from a longer period as supernumerary than is normal and had direct supervision from staff members designated to help her. That undermines the suggestion she was under-supported or left to fend for herself in an

unfamiliar environment.

14. Notably, even the performance management program was tailored to her wishes- for more specific, dated feedback for example.

15. It seems the department did all it could to support her through a process she failed to engage with in good faith.

16. Ms Suleiman-Reuben is described in various parts of the evidence, as putting in minimal effort. She is described as sitting on computers while ignoring patient bells, of not managing a significant load of patients, and of delegating large parts of her work. The fact that a number of witnesses have experiences with a similar apparent root personality cause, is relevant and the evidence on each should be read in the round.

17. The reliability of Ms Suleiman-Reuben's evidence is inevitably in question. In oral evidence she said she did not remember most details or incidents. She could not recall the basic facts of a number of incidents and the Panel should exercise caution in accepting any factual information she puts forward in that context.

Conspiracy

18. Ms Suleiman-Reuben appears to blame all those around her. In her evidence she said that she believed she had done nothing wrong during her time on Bernard Sunley ward.

19. Ms Suleiman-Reuben's criticisms of the team around her have become increasingly severe. No suggestion of bias was put to [Witness 1] at all. Some witnesses were asked about a conspiracy against her ("ganging-up"). Only with the final witness was an apparent motive put- that of a complaint made against [Witness 6]. By the time of giving her own evidence, Ms Suleiman-Reuben suggested there was a concerted conspiracy against her, directed by [Witness 1] to ensure that she failed and would be driven out of the ward.

20. The Panel is invited to reject that suggestion. The documentary evidence demonstrates that the process was followed correctly to address specific criticisms, and efforts were made to tailor the system to Ms Suleiman-Reuben's requirements. From that, wider concerns became apparent and were addressed.

21. The fact that the most severe suggestions were either not put, or only put to later witnesses suggests that they have been formulated or exaggerated during the course of proceedings. That, the Panel is invited to conclude, is consistent with the difficulties staff had locally in attempting to manage Ms Suleiman-Reuben.

22. It is also notable that the suggestion of a local collusive conspiracy does not feature in the "Letter of Concerns" submitted on day one of this hearing and it appears the first time it has been suggested is part-way through this hearing.

23. The way in which the allegations have expanded also undermines her credibility as a witness (as distinct from reliability, above). It appears Ms Suleiman-Reuben is willing to attack those around her with very little basis on which to base those attacks. In light of all of that the Panel is invited to exercise caution in accepting her factual evidence across the charges.

24. The Panel has had an opportunity to assess Ms Suleiman-Reuben's willingness or capacity to engage directly with questioning or challenge as she has given evidence. It is entitled to rely on that assessment in weighing the evidence of those who dealt with her at work. It is submitted their apparent frustrations are borne out in the way she gave her evidence.

25. At times she would give directly contradictory answers to questions, oscillating between binary options. She would fail to engage in straightforward questions. Often her answer would be tangentially related to the question, at best. It appeared she was taking the conversation where she wanted it to be with little regard to the questions

she was asked.

26. The Panel is also invited to view, with some sympathy, the evidence given by the witnesses about how difficult it was to challenge Ms Suleiman-Reuben, or to manage her in a way she would accept. The Panel can safely conclude the fault does not lie with "mismanagement" (another allegation not put directly to [Witness 1] for example).

Charge 3- neurological assessments

27. [Witness 8] conducted a formal assessment. The Panel has heard that he was brought in to ensure a neutral assessor after concerns were raised by Ms Suleiman-Reuben about the quality of assessment she had previously been exposed to. She did not pass that assessment.

28. It is unclear what the defence is to this charge, save that the tests were in some unspecified way too specific. Ms Suleiman-Reuben does not remember the detail of the assessments but says she would not have done what the records indicate she did.

29. She also appears to accept that it is the CPF who assesses and passes nurses. For that reason, the views of her own mentor- who was assigned later in the process in any event- are not relevant to the test she was undergoing.

30. Simultaneously Ms Suleiman-Reuben appears to accept she had learning to do- she suggested she is "less perfect" than people who have worked on that ward for years and to say that she had more than a decade of experience and could not legitimately have failed. She also suggests, without basis, that the CPFs were instructed to fail her by [Witness 1].

Charge 4a)- Poor communication with Patient A

31. [Witness 2] deals with the issues surrounding the self-discharge. She is clear that

the patient told her he self-discharged as a result of Ms Suleiman-Reuben's lack of compassion, empathy, and poor communication skills. The Panel is invited to accept that clear evidence.

32. It is notable that Ms Suleiman-Reuben was quite adamant that [Witness 2] was a newly qualified nurse and not part of the leadership. It is clear that she does not, therefore, have a recollection of this witness as a member of the conspiracy against her.

33. [Witness 1] gave evidence of having asked another member of staff to go through the discharge summary with Patient A because he could not understand the Registrant.

Charge 4b)- Management of Patient A's self-discharge

34. Ms Suleiman-Reuben accepts that this patient left with a cannula in situ and had to recall the patient, which she says she did soon after he left. The NMC submits that alone means his self-discharge was not managed adequately and the need to recall him is proof of that.

35. She argues that there was no opportunity because the discharge was completed "as an emergency" against medical advice. She does not engage with suggestions as to when a body check could have been completed. Notably, the patient returned when asked, which suggests the body check could have been completed had there been proper communication with him around the discharge.

36. That could have happened when the initial agreement was reached that the patient was leaving, his son could have been asked about it when he came to collect paperwork, it could have been completed when the patient was at reception with security and an HCA was dispatched to sit with him. It is simply not true, even on Ms Suleiman-Reuben's own narrative, to say there was no opportunity.

37. The failure to escalate that situation was specifically commented on in oral evidence by [Witness 1]. In her statement she indicates that the Registrant did not initiate the recall process. That was not challenged in cross-examination although it contrasts with the case now advanced by Ms Suleiman-Reuben.

Charge 6- Refused to help Patient C

38. [Witness 1] not only recounts the incident, but also the Registrant's reaction when she "addressed her manner". It is submitted that specificity of evidence cannot be misremembered.

39. The Panel is invited to conclude that [Witness 1] is a more credible witness than Ms Suleiman-Reuben, who can only explain the evidence on this charge by reference to the increasingly outlandish conspiracy she alleges there was against her.

Charge 7- incorrect volume of feed

40. [Witness 1] explains that the dietician visited the patient before they came to the ward and changed the prescription there. She describes the way that this patient was dealt with as "the perfect situation" to be contrasted with one where the dietician had to come to the ward to finalise the prescription.

41. She also notes, although the documents are not available, that the prescription was written on the chart (in oral evidence), and that this incident led to her submitting a datix (paragraph 69).

42. It is submitted that those are extraordinary details to remember if she is not correct. It is more likely that [Witness 1] is recalling the incident correctly and Ms Suleiman�Reuben [sic] *made a mistake through lack of competence or negligence, than that [Witness 1] has fabricated this incident in detail.*

Charge 8- incorrect administration of Enaxoparin

43. [Witness 1] is clear that Enaxoparin is given to all patients unless contraindicated, which it was in this case. She says in oral evidence that withholding the medication was mentioned in handover, and in the progress notes. Importantly, in her witness statement (para 71) [Witness 1] is clear that she, herself, gave the instruction to Ms Suleiman-Reuben.

Charge 10- unprofessional behaviour towards colleague B

44. It is alleged that Ms Suleiman-Reuben asked [Witness 7] "have you does this before or not". [Witness 1] reports the words differently as "are you a third-year student or what". It is the position of the NMC that those versions of the words have the same effect.

45. The allegation rests on the tone and context of the question, rather than any suggestion that the words themselves are unprofessional. It is accepted that the content of what is alleged to have been said could be a constructive attempt to gather information.

46. The words, in the context described by [Witness 7], had the effect of damaging her confidence, and making her feel uncomfortable. She said, in oral evidence, that she withdrew from feeding the patient as a result.

47. The Panel would be entitled to find that the words were belittling to [Witness 7] and dismissive of her skills and abilities, whether by design or not.

48. She says that she handed over the task as a result of the words said to her. Ms Suleiman-Reuben accepts that would not be her aim if she had asked the question benignly.

Charge 11- One-handed injection

49. Once again, the defence to this charge appears to be that there was a conspiracy against Ms Suleiman-Reuben. The Panel is invited to reject that suggestion. [Witness 7] worked on the ward for a short period in February and March 2021, a year after the alleged incident with [Witness 6]. When that was pointed out, Ms Suleiman-Reuben was only able to suggest she had been recruited by [Witness 6] into the conspiracy.

50. Ms Suleiman-Reuben was able, in oral evidence, to explain the proper practice, and to say that she always practises in line with her duties. She says it would be unprofessional to complete the injection one-handed. She is right, and that is the allegation against her.

51. [Witness 7] it seems, had no particular axe to grind with Ms Suleiman-Reuben, but has reported her concerns precisely because it was unusual and unprofessional.

52. The Panel may well conclude the attitude alleged in this incident is reflective of the attitude alleged by other witnesses and, to some degree, demonstrated in Ms Suleiman-Reuben's responses to questioning.

Charge 12- single person hoist use

53. This charge comes down to a direct conflict between the evidence of [Witness 7] and Ms Suleiman-Reuben. The Panel is invited to conclude that [Witness 7] is a reliable witness recounting an event that caused her concern.

54. Mr Suleiman-Reuben's response to the allegation amounts to an explanation that to give the instructions she is alleged to have given would be unprofessional. That is right, and is the allegation against her.

Charge 13- Access to intermittent self-catheterisation

55. This is an example of a charge where the witness was questioned on why they did not intervene earlier. [Witness 2] was entitled to expect that Ms Suleiman-Reuben would complete her responsibilities. This is particularly true where [Witness 2] gives evidence of having specifically raised an issue with her on top of it being in the handover.

56. Ms Suleiman-Reuben appears to recall the patient in some answers but not in others. The Panel is invited to have regard to the email chain at [Witness 2] (p91) containing the details of the allegation recorded contemporaneously. Combined with the detail about catheters of the wrong size being found, the timing of that email gives additional reliability to [Witness 2] evidence.

Charge 14- Failure to administer Nimodipine

Note- there has been a suggestion that low blood pressure played a role in the care of this patient. That was not the evidence of the NMC witness, who has always referred to bradycardia. Low blood pressure was suggested in cross-examination

57. This is another charge where the detail was outlined in an email ([Witness 4]- p119) within days of the incident, suggesting the account of the witness is likely to be more reliable.

58. [Witness 4] in oral evidence, says she checked the notes and there was no instruction to omit Nimodipine when Ms Suleiman-Reuben chose to do so, nor a note of a conversation with a doctor. She was clear that she had been looking for a note specifically, so her recall of not seeing one can be safely relied upon.

59. Both parties agree that stopping Nimodipine is a medical, not a nursing, decision. If a doctor had not given an instruction to change the prescription or to act outside it, there appears to be no justification for not following the prescription in this case.

60. On p120 [Witness 4] outlines how she took the steps Ms Suleiman-Reuben ought to have.

Charge 15a) Spoke unprofessionally to colleagues during a handover

61. The detail of both parts of charge 15 is found in [Witness 4] email of 19 February 2021, two days after the shift where the incident occurred. In oral evidence she was asked how clear she was in her recollection and replied "very clear" explaining that she was shocked to hear the comment about gossip without context, particularly as she was discussing the patient with a colleague as part of their own nurse-in-charge handover.

62. Ms Suleiman-Reuben accepts that the words alleged would be unprofessional. The Panel is invited to reach the same conclusion. The words are dismissive, aggressive, and unnecessarily belittling. That would be true even if the conversation had not been work related but is particularly the case where it is.

Charge 15b)- Did not provide handover in a structured manner

63. Ms Suleiman-Reuben is unable to comment on the specifics of this handover, in contrast to [Witness 4] who does so in detail in her statement at paragraphs 24-25.

Charge 16- Administered Gentamicine without clinical reason

64. Ms Suleiman-Reuben's recollection of this patient is entirely inconsistent with [Witness 2]. She recalls that the patient had a catheter in place and questions whether [Witness 2] was even on the shift.

65. She was unable to explain why questions asked on her behalf appeared to accept there was no catheter, and to explore whether a plan had been formulated to insert one.

66. [Witness 2] raised a datix in relation to this incident. It is clear that she was involved in it. Ms Suleiman-Reuben's recollection is entirely unreliable, and [Witness 2] should be preferred.

Charge 17- Behaved unprofessionally towards colleague C by shouting

67. Notably, Ms Suleiman-Reuben was unable to recall who the subject of this incident was, despite having received the documentation in advance of this hearing. She was said to have believed it was an incident with someone called [Person B], when she did not recognise [Witness 5] on screen.

68. Ms Suleiman-Reuben says that she was rudely asked if she was ready for handover. Calmly she said that was rude and [Witness 5], raised a middle finger at her. She says she did not respond to that provocation. She also denies that she was taken into an office to have a conversation, which the witnesses report.

69. The Panel are invited to conclude that it is simply beyond comprehension that Ms Suleiman-Reuben's version of events is correct. First, it was not put to [Witness 5] in the terms it is now alleged, giving the impression of having been dreamed up after the fact. Second, three different witnesses report seeing Ms Suleiman-Reuben pursuing [Witness 5] and shouting in the process, including in written statements within two days of the incident (p105, p126, p129). It is simply inconceivable that she did not shout.
70. [Witness 4] said, in oral evidence:

She came from Bay 3 to bay 2 to the nurse's station shouting about what happened to [Witness 5], with [Witness 5]. Already saying we did not respect her and things like that, so at that point clearly an attitude that I was not expecting from that moment, at the handover that would have all the nurses and HCAs starting a shift. I took her to the

office to have this conversation.

71. If she perceived the request "are you ready for handover?" as having been delivered rudely, there is no justification for shouting at [Witness 5] , nor for accusing her of being unprofessional in the hearing of patients and colleagues. Even if there was a momentary lapse, pursuing her out of the bay elevates it to unprofessional conduct in any circumstances.

Charge 18- Unnecessarily interrupted handover

72. It is accepted that a nurse should ask questions in handover, even basic ones if they are unclear. However, they are also required to listen to handover, and to respect colleagues giving that handover.

73. In response to questions from the Panel, [Witness 6] said that this sort of patient comprised 50% of the caseload on the ward, so that after a year of working there she would expect a nurse to be quite knowledgeable about how to deal with them. She noted it is one of the first pieces of training they do. That indicates that the questions Ms Suleiman-Reuben was asking, arise from her not paying attention, rather than from a need to gather basic information.

Charge 19- avoided answering nurse bells without justification

74. [Witness 6] was challenged that her complaints against the Registrant arose from her being upset that Ms Suleiman-Reuben made a complaint against her early in her time on the ward. The Panel will note how confused [Witness 6] was by that suggestion, apparently unable to recall any such complaint.

75. Importantly, [Witness 6] evidence on this allegation included information about Ms Suleiman-Reuben's activity at the time of at least some of the bells she failed to

answer. She indicated that some bells related to patients allocated to Ms Suleiman-Reuben, and that the Registrant was sitting within meters of the patients on a computer at the time. She also answered that she noticed the failure to answer bells particularly after lunch. That is the sort of specific detail that helps to elevate a general impression into reliable evidence.

76. She said that she, and colleagues would answer the bells and she would sometimes as Ms Suleiman-Reuben to do so.

77. When asked about shifts with the Registrant generally, [Witness 6] said:

I always had some concerns regarding patient care. I always had a stressful day when that shift was coming for me. That I remember perfectly because in the morning I was already stressing and being so much more careful and attentive than I usually am on those shifts.

Charge 20a)- Behaved unprofessionally by shouting at colleague B
Charge 20b)- Using words to the effect of "are you all fucking stupid…"

78. [Witness 6] gave evidence that, as a result of this incident, she sought out her manager, then left the ward, going to a park where she sat and cried. She says she returned to the shift two hours later.

79. It is submitted that a senior nurse is highly unlikely to have had such a reaction to anything but clearly unprofessional behaviour. The Panel can put significant weight on the fact that the Registrant's superior was so affected that she could not continue working immediately.

80. The Panel is entitled to consider the impatience Ms Suleiman-Reuben showed in answering questions in this hearing when assessing this charge.'

Registrant's Closing Submissions

Dr Akinoshun submitted that Witness 1 had acknowledged that you had not previously worked in the neurosurgery environment. Although this witness had confirmed that there was a plan for regular meetings to be held with you in order to support you, there is no evidence of any structured or regular meetings with her. Consequently, Dr Akinoshun confirmed that Witness 1 had admitted that there was no clinical supervision structure on the unit, and therefore, no evidence of clinical supervision with you. He submitted that this provides insight into the kind of structured support mechanism which was in place for a new staff member, such as yourself, who had arrived to work in such a specialised environment.

Dr Akinoshun highlighted that Witness 1 also acknowledged that you had approached her to express your concerns regarding the conspiracy against you, amongst staff. Witness 1 also acknowledged in the course of her cross examination, that both her and another colleague drafted an action plan without having gotten you involved. Consequently, it is clear that there is a lack of openness and transparency in the way matters were managed on the hospital ward.

Dr Akinoshun submitted that Witness 1 accepted during her cross examination, that feedback was not provided to you, as staff were not comfortable to express concerns with you, and this is why matters were dealt with through Witness 1 as the manager. Dr Akinoshun submitted that this is what led you to believe there is some level of conspiracy against you, as you felt as though your colleagues were looking for *'every opportunity to put their cases together'* against you.

Dr Akinoshun referenced the NMC Code of Conduct and stated that the nurses who worked along with you held a duty to escalate any concerns they had, as soon as possible. He stated that it is their professional duty of candour by being open and honest whenever they are dealing with their colleagues.

Dr Akinoshun submitted that, as you were not communicated with, you were deprived of the opportunity for self-reflection and ability to modify your behaviour. He submitted that your nursing colleagues, and the witnesses involved in this case, deliberately did not discuss their concerns with you in an aim to collate their cases and cause further escalation.

Dr Akinoshun submitted that, in relation to Charge 4, Witness 1’s written statement confirmed that the patient had the mental capacity to make a decision regarding self-discharge. He submitted that this should be taken into account by the panel, in relation to your decision, and actions in this charge.

Dr Akinoshun submitted that there are no contemporaneous notes made by Witness 1 in relation to your performance, behaviour, and actions. Consequently, Dr Akinoshun submitted that the allegations against you are ingenuine, with no record of the concerns at those particular times. He submitted that the panel should consider the credibility of the evidence presented by Witness 1.

Dr Akinoshun then moved onto the credibility and reliability of the remaining 6 witnesses.

Dr Akinoshun submitted that Witness 4 had acknowledged during her evidence that you had accused the team of ganging up against you but dismissed this allegation in her statement. He submitted that Witness 4 did not conduct any fact-finding exercise, even though you had verbalised your concerns.

Dr Akinoshun submitted that the charges against you occurred between three and four years ago, between 2020 and 2021. He submitted that the evidence provided by you has been credible and reliable, and given to the best of your ability. Dr Akinoshun submitted that you could be considered to have been on somewhat of a ‘hot seat’ when you were giving evidence, which led to some level of stress and impacted the way you gave evidence to the panel. He highlighted that whilst you were under oath, would not deliberately mislead the panel in any way.

Dr Akinoshun submitted that you qualified as a registered nurse in 2004, 20 years ago, making clear that you must have developed some skills and knowledge over the previous years.

Dr Akinoshun submitted that there is no justification for not challenging you on your poor practice during your time at the Trust; he highlighted that the 'excuse' given by your seniors regarding 'not being comfortable to challenge' Ms Suleiman-Reuben's poor practice, ultimately put patient safety at risk.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Dr Akinoshun.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Harper on behalf of the NMC and by Dr Akinoshun on your behalf.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Band 7 Nurse and Ward Sister at University College National Hospital for Neurology and Neurosurgery.

- Witness 2: Epilepsy Clinical Nurse Specialist
- Witness 3: Deputy Sister
- Witness 4: Clinical Practice Facilitator
- Witness 5: Band 5 Nurse
- Witness 6: Staff Nurse
- Witness 7: Student Nurse (at the time of the charges).

The panel also heard evidence from you under affirmation.

Dr Akinoshun submitted that the allegations arose out of a *'conspiracy'* against you by your colleagues. Therefore, before any deliberations, the panel considered the Cambridge Dictionary definition of the word *'conspiracy'*, which is as follows:

> *'The activity of secretly planning with other people to do something bad or illegal.'*

In relation to the above, the panel regarded Witness 1, Witness 2 and Witness 4 as consistent and credible witnesses. The panel highlighted that these witnesses had a *'remarkable'* level of consistency between their written and oral evidence, which were re-confirmed by contemporaneous evidence.

The panel were of the view that there is no cogent evidence of a conspiracy having been created against you, and noted that all witnesses, when questioned on the proposed *'conspiracy'*, consistently denied this claim.

The panel then considered each of the disputed charges and made the following findings.

Charge 3)

> **'***On 17 March 2020 failed to complete neurological assessments accurately or in a timely manner'*

In considering this charge, the panel took into account the witness evidence of Witness 1, whom it considered to be a credible witness. The panel noted that her oral evidence was entirely consistent with her written evidence. The panel took into account the contemporaneous evidence of assessments prior to the genesis of this charge and noted Witness 1's statement regarding the amount of time that it would normally take a nurse to gain the relevant skills to complete this assessment in a timely manner. The panel noted that Witness 1 had stated that you took considerably longer to complete the assessments.

The panel also took into consideration your oral evidence, in which you stated *'I will not be as perfect as nurses who trained in neurological assessments…'*

On the balance of probabilities, the panel found this charge proved.

Charge 4a)

> *'While on a formal performance management action plan after 7 August 2020:*
> *On or about 3 November 2020:*
> *a. Did not communicate effectively with Patient A'*

In relation to this charge, the panel heard evidence from Witness 1 and Witness 2. It heard evidence that when a patient threatens to self-discharge, a registered nurse is expected to de-escalate the situation by listening to the patients concerns and offering clear advice about the next steps which should be taken to enable the patient to be discharged safely. The panel determined that a registered nurse would be expected to be empathetic with the patients' frustration.

You gave evidence to the panel that the patient was *'aggressive'* and difficult to calm down.

The panel preferred the evidence of Witness 2, who gave evidence that you did not behave in a way which fulfilled the expectations of a registered nurse in this situation. Witness 2 submitted the following:

> *'Within this situation, Ms Suleiman-Reuben should have actively listened to the patient about his concerns, and she should have been sympathetic to his communication difficulties. If she could not have understood the patient, she should have asked for help.'*

On the balance of probabilities, the panel found this charge proved.

Charge 4b)

> *'On or about 3 November 2020*
> *b. failed to manage Patient A's self- discharge adequately or at all.'*

In relation to this charge the panel took into consideration the witness evidence of Witness 1. The panel noted that Witness 1 has provided corroborative evidence, in that her oral and written statements are both consistent with one another.

The panel did note the fact that you had claimed not to have realised that the patient had a cannula in, because the patient had a coat on and over their arm. However, the panel was not convinced by your evidence, as you provided no robust or significant response when you were cross-examined. In your evidence you accepted that cannula removal was part of a safe patient discharge, and that you failed to ensure that this was done.

The panel determined that, under no circumstance should a patient be able to leave the ward with a canula still in place, as this is not an effective or safe management of self-discharge. The panel determined that you failed to manage this risk.

On the balance of probabilities, the panel found this charge proved.

Charge 6)

> **‘***On a date prior to 11 November 2020 refused to help Patient C.’*

In relation to this charge the panel determined that Witness 1’s evidence is clear, consistent and reliable. This charge originated by a complaint from a patient made to Witness 1. The panel determined that her live testimony accords with her witness statement, with no deviation. Witness 1 had stated that you had said you were *‘too tired to help’.*

The panel noted that you stated that you *‘do not remember this* day’ but also denied this charge. You submitted in your evidence that you *‘came to this job because [you] have a passion for it [you are] obliged to keep patients safe…’*

The panel determined that it preferred the evidence of Witness 1.

On the balance of probabilities, the panel found this charge proved.

Charge 7)

> ‘*On 4 December 2020 administered an incorrect volume of feed to a patient.’*

In relation to this charge, the panel considered the evidence of Witness 1 and considered the fact that the patient had been seen by the dietician and that there was an entry on the Epic computer entry system, which stated the following:

'By the end of the shift I noticed that Ms Suleiman Reuben had started the feed but the dose was not the prescribed one. It was lower than the prescription so less feed was administered. The volume of the feed recorded on the pump as 'volume fed' was half of what the dietician prescribed, and the patient received half of his nutritional support for that day. A datix report was completed but I cannot locate it … When I raised this error was Ms Suleiman Reuben she did not seem to think this was a relevant error and was not interested in hearing about it. She would not engage with me on this incident'

The panel then considered your response, which was that you *'totally disagree'* with Witness 1's statement.

The panel did not have the datix before it. Although the panel did not have sight of this, it found the witness to be credible and they were sufficiently concerned about the situation to complete a datix.

The panel determined that it prefers the evidence of Witness 1.

On the balance of probabilities, this charge is found proved.

Charge 8)

'*On 5 December 2020 incorrectly administered Enaxoparin to a patient.'*

In relation to this charge the panel considered the evidence of Witness 1 and took into account her statement that she had given you instructions to withhold the medication, but that you still administered it. After the administration, when it was brought to your attention, Witness 1 submitted in her written statement, that *'Ms Suleiman Reuben did not seem concerned by her error as the patients' surgery was cancelled anyway'*.

The panel considered the fact that you submitted that you do not remember this incident, but also claimed *‘I would not jeopardise this, it did not happen’.*

The panel determined it prefers the evidence of Witness 1, as opposed to your evidence, and determined that it is more likely than not that you did incorrectly administer Enoxaparin to the patient after being told to withhold it.

On the balance of probabilities, the panel find this charge proved.

Charge 10)

> ‘*On a date between 8 February 2021 and 14 March 2021 behaved unprofessionally towards Colleague B by saying words to the effect of “have you done this before or not”.’*

In considering this charge, the panel took into consideration the witness evidence of Witness 1, Witness 6 and Witness 7. The panel took into account the witness evidence of Witness 7, in which she stated that she was *‘really upset’* and felt as though she was being treated as an *‘idiot’*. The panel further considered Witness 7’s statement that you had made her feel *‘incompetent, just for asking a question.’* Witness 7 gave oral evidence that you shouted at her *‘in the middle of the ward’* asking her *‘have you done this before?’.*

The panel also took into account your evidence in which you submitted that you were never rude, had used a soft tone, was *‘very accommodating’*, and would not shout at a student as it would be *‘unprofessional’* to do so.

The panel determined however, that it is more likely than not that you did administer the injection using only one hand and considered Witness 7’s evidence to be clear and supported by contemporaneous written evidence of Witness 1 and Witness 6, namely, an email in which Witness 6 reported the incident to Witness 1.

On the balance of probabilities, the panel found this charge proved.

Charge 11)

> *'On a date between 8 February 2021 and 14 March 2021 administered an injection using only one hand instead of two.'*

In relation to this charge, the panel considered the evidence of Witness 6, Witness 1, and also Witness 7, in which Witness 7 had stated that she remembered this incident occurring as it was *'pretty unusual'*. Witness 7 stated that you *'administered an injection with one hand holding the syringe and the other on [your] hip.'* Witness 7 went on to say, *'you must always use two hands when administering an injection'.*

The panel noted that you had rejected that Witness 7 was ever present when the injection was administered. You stated that Witness 7 had been manipulated into making this false allegation towards you. You also stated that this allegation was part of a *'conspiracy'* made against you.

The panel determined however, that it is more likely than not that you did administer the injection using only one hand and considered Witness 7's evidence to be clear and supported by contemporaneous written evidence of Witness 1 and Witness 6.

On the balance of probabilities, the panel therefore found this charge proved.

Charge 12)

> *'On a date between 8 February 2021 and 14 March 2021 instructed a student nurse to hoist a patient without a second person to assist.'*

In relation to this charge, the panel determined that there is an absence of first-hand evidence that corroborates the account of Witness 7's evidence. The panel took into

account your denial, and statement in relation to this charge, that *'[Witness 7] is lying' … 'this never happened'.*

The panel were of the view that the NMC have not provided adequate evidence to support this charge.

On the balance of probabilities, the panel found this charge not proved.

Charge 13)

> '*On 13 February 2021 failed to ensure that a patient was supplied, adequately or at all, with the means to carry out intermittent self-catheterisation.'*

In relation to this charge, the panel considered the evidence of Witness 2 and determined that her evidence is both credible and reliable. The panel determined that Witness 2 has also provided contemporaneous documentary evidence to support her statement.

In an email from Witness 2 to Witness 1, she stated:

> *'I approached her regarding the ISCs numerous times as I worried about the patient…'*

The panel also noted Witness 7's evidence in which she said it was your *'responsibility to ensure that the patient was able to empty their bladder ... [you] failed to facilitate this … As a result of this, the risk of infection to the patient was heightened.'* She further stated, *'I helped [you] find ICS's but they were of the wrong size.'*

The panel noted that you, in your evidence, said *'I cant remember … I don't remember anything about catheters … no it didn't happen … I don't agree about the wrong size of the catheter … it did not happen.'*

The panel determined that you have been contradictory in your account of this charge, and incoherent when providing evidence. The panel preferred the evidence of Witness 2.

On the balance of probabilities, the panel found this charge proved.

Charge 14)

> ‘*On 16 February 2021 failed to administer Nimodipine to a patient.’*

In relation to this charge, the panel accepted that you, as a registered nurse, held a duty to carry out the function of giving a patient their appropriate medication as prescribed, or, to seek medical opinion from colleagues. The panel were of the view that this charge relates to a failing of basic nursing care.

The panel noted Witness 4 and Witness 7’s evidence, in which Witness 4 described the event and you having failed to provide Nimodipine. The panel took into account that Witness 4’s live evidence accorded well with her written evidence. Witness 4 stated *‘[you] had failed to give the patient his required dose of nimodipine. When I asked [Witness 7] what the nimodipine plan was for this patient, [you] interrupted and replied that it was up to [Witness 7] whether [Witness 7] gave the next dose of nimodipine to the patient, due to his bradycardia […] Within this situation, a doctor should have been made aware that the patient was bradycardic, and the doctor would then, make a decision, on the next steps in the patients care.’*

The panel noted that following the intervention of Witness 4, the Nimodipine medication was given. The panel was of the opinion that if you had fulfilled your responsibility as a registered nurse, in relation to administering this medication, then Witness 4 would not have been required to intervene. The panel noted Witness 4’s escalation of this incident, as she perceived it to be serious.

The panel noted that there was no significant challenge against this charge from your representative, Dr Akinoshun. The panel noted that you stated, *‘I can’t remember this happening […] I can’t remember [Witness 7] handing over the patient […] these are lies from [Witness 4].’* The panel determined that your evidence was implausible and inconsistent, and relied heavily on a conspiracy existing against you, which the panel have determined, it did not.

The panel concluded that you had a duty to give the medication, or seek appropriate instruction not to give it, and in failing this, you also failed a basic nursing skill. The panel took into consideration the email from 19 February 2021, in which Witness 4 stated the following, to Witness 1, in written form:

> *‘On the 16th, I came to do my night shift and we were all at the nursing station doing the handover when it came to bed 11, Rashee left the student [Witness 7] to handover the patient. The patient was admitted under the diagnosis of SAH and was, at that time, on Nimodipine 4 hourly. According to the handover, the patient was bradycardic during the day at 40 bpm, the doctors were informed and an SHO gave an order to omit that dose of Nimodipine. When I asked what was the Nimodipine's plan, Rashee interrupted the student and said that it was up to me to give or not because she didn't give that dose due patient's bradycardia. I told her that was not up to me that should be a plan for the next doses of Nimodipine and this medication shouldn't be stopped like this due to the risks for the patient. Rashee became aggressive saying that I would have to chase the doctors regarding this because she couldn't do it, but I got the impression she didn't understand why this couldn't be done or why shouldn't be done.’*

The panel preferred the evidence of Witness 4.

On the balance of probabilities, the panel found this charge proved.

Charge 15a)

> *'On 17 February 2021 during a handover*
> *a. spoke unprofessionally to colleagues during a handover'*

In relation to this charge, the panel took into account the contemporaneous evidence of Witness 1 and the evidence of Witness 4, in which she states you having been aggressive, and shouting *'can you stop your gossip'* in the presence of other staff. Witness 4 further stated that your behaviour was *'inappropriate'* as you were speaking to the staff as though they were *'children'* using a *'loud and aggressive voice'.*

The panel noted that you reject having shouted these words and gave evidence that you *'don't remember using the word gossip'*, and that you *'don't use'* this vocabulary. You further stated that *'you definitely didn't say'* this, and were likely to have said *'can we please listen to the handover'.*

The panel determined that the evidence of Witness 4 is preferred over your evidence.

On the balance of probabilities, the panel found this charge proved.

Charge 15b)

> '*On 17 February 2021 during a handover:*
> *b. did not provide handover information in a structured manner.'*

The panel determined that a 'structured manner' is a manner in which others can understand the progress of a patient. In this incident, the panel noted that Witness 4 had stated in their email to Witness 1, the following:

‘On my next night, Rashee was doing the handover of bed 12, handover difficult to follow due to disorganize and unclear information that she was giving about the patient…’

Witness 4 gave evidence about normal handover procedures. She then went on to say:

‘During this handover [you] were bouncing back and forth between the categories of information and as a result, there were some gaps in the information that we were receiving … I recall that her handovers had no structure and were difficult to follow.’

The panel noted that you recount that you do know how to provide a hand-over to a colleague, and your claim that this charge was *‘made up’*. You further stated that you are *‘trained on handover structure’* and you acknowledged that you must have *‘effective communication’.*

On the balance of probabilities, the panel found this charge proved.

Charge 16)

‘*On 15 March 2021 administered Gentamicin to a patient without clinical reason.’*

In relation to this charge, the panel considered the evidence of Witness 2, alongside the evidence of Witness 1 who stated that you had ‘*administered medication to the patient without a clinical reason’*. This was the conclusion of Witness 1 from reading the datix relating to this particular patient. It was stated that *‘gentamicin was only to be administered to Patient A if there was a urinary catheter change… as a foreign body is entering the patient. Patient A did not require a new catheter when [you] administered the medication. This was a mistake on the part of [you] as there was no clinical need to administer gentamicin as no new catheter needed inserting.’* The panel concluded that the evidence of both Witness 1 and 2 are credible.

You stated in your evidence that you were *'instructed'* to administer Gentamicin as the *'patient was going into retention'* and that it was *'the doctors decision … they go to the nurse directly and they said its on the board and was prescribed intravenous … I did it pre and post.'* You further stated that you remember this very well and had checked with the doctor as it was *'not up to'* you, but the *'doctors directive'.*

The panel determined that your account relating to this charge did not make sense, and you did not seem to have an understanding for the reasoning for the checking of pre- and post-Gentamicin levels.

The panel determined that it is more likely than not that you did administer Gentamicin without clinical reason.

On the balance of probabilities, the panel found this charge proved.

Charge 17)

> **'***On or about 15 March 2021 behaved unprofessionally towards Colleague C by shouting.'*

In relation to this charge, the panel took into account the evidence of Witness 5, in which she stated that she was shouted at, which was supported by Witness 2 in her evidence also. The panel noted that Witness 2 had claimed to have taken you into a side room, all of which was documented contemporaneously. Witness 5 stated *'I asked [you] if you were 'ready for hand over', [you] then started shouting at me… that I was rude and impolite for asking if she was ready for hand over… [you] were verbally aggressive and [your] reaction to my question shocked me. I did not know how to react so I went to the nurses station to calm down. [you] followed me and continued shouting at me stating I was unprofessional and rude.'* Witness 2's evidence was *'I was taking hand over from a colleague… when Witness 5 ran past the nurses station in to the managers office. Witness 5 was crying.*

[you] followed Witness 5 to the nurses station, shouting loudly… I do not recall what [you] were shouting but I recall that [your] behaviour was unprofessional.'

The panel heard, when you were questioned by Mr Harper regarding this charge, and whether or not you remembered having shouted at a colleague, you claimed that all three witnesses were *'lying'*. You submitted in your evidence that you are *'more experienced in life than her [your colleague], how would I shout at her, it's impossible'.*

The panel determined that when considering the weight of the evidence from the witnesses relating to this charge and your evidence, the panel preferred the evidence of the witnesses.

The panel determined that on the balance of probabilities, this charge is found proved.

Charge 18)

> '*On an unknown date in March 2021, unnecessarily interrupted handover involving a patient receiving Nimodipine.'*

In relation to this charge, the panel noted the evidence received from Witness 6, who stated *'on handover of this patient [you] interrupted the handover from the nurse by asking weird questions although I cannot recall what these questions were. I do remember that she was asking questions out of subject of the handover and she was just repeating what the handover nurse was saying regarding the patient. Her tone of voice when repeating the questions was inappropriate and she seemed inattentive and unaware of what was being said by the handover nurse just a few seconds previously.' […] 'as a result of [your] behaviour during handover, throughout the day I had to read through the patients medical records to ensure that I had not missed any vital information.'*

The panel then determined that Witness 6 has provided a plausible account for you having interrupted the handover, and *'asking weird questions',* although, Witness 6 was unable to

recall what exactly those questions were. Witness 6 submitted that you were asking questions in an abrupt tone of voice.

The panel noted that you did not remember the situation relating to this charge and did not engage with the questioning posed by the NMC. You submitted that you *‘don’t know’* what Witness 6 is talking about, and that you disagreed, stating that you *‘was listening’*. You submitted during your oral evidence that *‘you do need to be able to ask questions if you are not clear’.*

The panel found the evidence of Witness 6 credible and plausible and therefore determined that the NMC have provided sufficient evidence.

On the balance of probabilities, the panel found this charge proved.

Charge 19)

> ‘*On one or more occasions on dates unknown avoided answering nurse bells without justification.’*

In relation to this charge, the panel did consider the evidence of Witness 6, but determined that there is a lack of evidence to prove what exactly you were doing at the time relating to this charge. The panel determined that there is no evidence that you did not answer the bell without justification, and that this charge is unsupported by any form of contemporaneous documentation.

On the balance of probabilities, the panel found this charge not proved.

Charge 20a)

> *‘On an unknown date in March 2021 behaved unprofessionally by:*
>
> a. *shouting at colleague D’*

In relation to this charge, the panel took note of the statement made by Witness 6, who said *‘I recall what [you] shouted at us as myself and my colleagues were stunned into silence. [you] shouted at us […]’* Witness 6 further stated that your behaviour was *‘inappropriate, unprofessional and showed poor communication skills especially on the ward with colleagues and patients around.’*

The panel took into account the fact that Witness 6 did not escalate this alleged situation by reporting it to management.

The panel considered your evidence, in which you stated, *‘I can’t remember shouting’* and claimed that this accusation is *‘all made up’,* as your colleagues were all *‘ganging’* up against you. You further stated that this entire situation was *‘over exaggerated’.*

The panel accepted your evidence that you did not shout at Colleague D.

Therefore, the panel found this charge not proved.

Charge 20b)

> *‘On an unknown date in March 2021 behaved unprofessionally by:*
> *b) using words to the effect of ‘are you all fucking stupid. Can you hurry right now because I’m going to bay 1, bye.’*

In relation to this charge the panel determined that there is insufficient evidence before it to find this charge proved. The panel took into account the fact that Witness 6 did not escalate this alleged situation by reporting it to management. The panel noted that, under cross examination, Witness 6 could not recall that the words in this charge were used and stated that she *‘cannot remember.’*

The panel noted your evidence whereby you stated, *‘It’s not my background I never used the word on my children how would I use this in a professional setting it’s not part of my lifestyle to use this language its unprofessional I don’t know why they are saying this.’*

It is for the reasons above, that the panel determined that this charge is found not proved.

NMC’s Replacement of the Lay Panel Member

At the resuming stage of this hearing, the lay panel member of this three-party panel was unable to continue and therefore was replaced by a new member. The panel heard and accepted the advice of the legal assessor, and considered the CMT-7 Guidance, along with Rule 6(10) and Rule 6(11) of the Nursing and Midwifery Council (Practice Committee) (Constitution) Rules of 2008 (as amended by SI 2020/821) when determining its decision on whether or not to resume and continue this hearing, with a new lay panel member.

Both Mr Smalley and Dr Akinoshun supported the continuation of this hearing with the replacement of the previous lay panel member, with a new lay panel member.

The panel determined that it would be reasonably practicable in the circumstances to sit as a panel of two in order to edit the determination of the facts stage of this hearing, which would comprise of the chair and registrant panel member. It was then decided that the third, new, lay panel member would join the hearing process once this has been completed, to engage with the remaining stages.

Fitness to practise

Having reached its determination on the facts of this case, and the fact that the misconduct charges in this case were found not proved, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of

fitness to practise. However, the NMC has defined fitness to practise as a registrant’s suitability to remain on the register unrestricted

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *‘A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.’*

Mr Smalley invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of ‘The Code: Professional standards of practice and behaviour for nurses and midwives 2015’ (“the Code”) in making its decision.

Mr Smalley identified the specific, relevant standards where your actions amounted to a lack of competence. Mr Smalley submitted that lack of competency needs to be assessed using a three-stage process:

- Is there evidence that you were made aware of the issues around your competence?
- Is there evidence that you were given the opportunity to improve?
- Is there evidence of further assessment?

Mr Smalley submitted that the facts found proved show that your competence, at the time the proven charges occurred, was below the standard expected of a registered nurse. He highlighted in particular, that your practice fell short in the following areas:

1) Communication and cooperation with colleagues and patients to ensure the provision of safe and effective care;
2) Breaches of confidentiality;
3) Failure to put the patient first;
4) Medication errors in terms of administration;
5) Simple failures to provide care when required.

Mr Smalley therefore submitted that your actions do amount to a lack of competence.

Dr Akinoshun submitted that you are an exemplary nurse who has been on the NMC register since 2004. He submitted that you have carried out nursing duties competently and safely for 17 years without any NMC referrals or similar allegations made against you, prior to 2020.

Dr Akinoshun submitted, however, that the findings of the panel do constitute a lack of competence.

Submissions on impairment

Mr Smalley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession

and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Smalley submitted that due to the charges found proved, it is suggested that you are not capable of practicing kindly, safely, or professionally.

Mr Smalley submitted that the first three limbs of *Grant* are engaged. He submitted that you had put patients at risk of harm and breached the fundamental tenets of the nursing profession, and therefore, brought the nursing profession into disrepute.

Mr Smalley acknowledged the number of training certificates you have provided, and the reference provided by your current employer. He further acknowledged that you have not provided a reflective piece. Mr Smalley submitted that the concerns in this case have not yet been remedied. He noted that the employment which you have undertaken in the past two years, whilst working in the clinical field, has not been within a nursing capacity. Consequently, you have not had the chance to improve your practice within this specific area. Mr Smalley submitted that therefore, you currently remain impaired on the ground of public protection.

Mr Smalley submitted that once the relevant public protection concerns are addressed, it would not be the case that the NMC apply for a finding of impairment on the ground of public interest. However, it was highlighted that, as the public protection concerns have not been addressed as of currently, your practice is currently impaired when considering the ground of public interest, also.

Dr Akinoshun submitted that, the panel should consider whether or not your fitness to practice is impaired as of today, not at the time of the incidents. He submitted, that you have continued to work within a health care setting, albeit, as a support worker. Mr Akinoshun submitted that you have demonstrated your fitness to practice, in that you have, in your current role, carried out your tasks safely and competently. He noted that,

within your current role, you deal with holistic care. Dr Akinoshun submitted that you have provided full time home care for the same individual for over a year, supporting them in all aspects of their care including their medication, appointments and hospital stays. The placement is via an agency, and you also communicate with the agency if any issues arise. Dr Akinoshun submitted that your communication skills in this area are transferable to a clinical setting.

Dr Akinoshun submitted that you have done *'everything in your power'* to gain a nursing role, or a role within a hospital setting. He submitted, however, you have failed to do so, as you have not found a supportive employer that will employ you with the interim conditions of practice order, currently imposed on your practice.

Dr Akinoshun led the panel through the registrant's impairment bundle, which included a number of references in relation to your recent and current practice.

Dr Akinoshun submitted, that in view of a lack of similar occurrences, as of this current date, the level of insight you have provided, and the remedial steps you have taken, such as training, your fitness to practice is currently not impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *General Medical Council v Meadow* [2007] QB 462 (Admin) and *Calhaem R (on the application of) the GMC [2007] EWHC 2606 (Admin).*

Decision and reasons on application for hearing to be held in private

At this stage of this hearing, Mr Smalley made a request that a part of this case be held in private on the basis that the name of Service User A's daughter was included within Dr Akinosun's submissions in relation to impairment.

The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Dr Akinoshun indicated that he supported the application to the extent that any reference to Service User A's daughters name, should be heard in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined that it would go into private session as and when the name of Service User A's daughter is mentioned, in order to protect the privacy of this individual.

The panel heard and accepted advice from the legal assessor.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

> **1) Treat people as individuals and uphold their dignity**
> 1.1) treat people with kindness, respect and compassion;
> 1.2) make sure you deliver the fundamentals of care effectively;
> 1.4) make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.
>
> **2) make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay**
> 2.1) work in partnership with people to make sure you deliver care effectively.
>
> **6) Always practise in line with the best available evidence**
> 6.2) maintain the knowledge and skills you need for safe and effective practice.

8) Work cooperatively

8.1) respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate;

8.2) maintain effective communication with colleagues;

8.4) work with colleagues to evaluate the quality of your work and that of the team.

13) Recognise and work within the limits of your competence

13.1) accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care;

13.2) make a timely referral to another practitioner when any action, care or treatment is required;

13.3) ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.

18) Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.1) prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person’s health and are satisfied that the medicines or treatment serve that person’s health needs.

20) Uphold the reputation of your profession at all times

20.1) keep to and uphold the standards and values set out in the Code;

20.3) be aware at all times of how your behaviour can affect and influence the behaviour of other people;

20.8) act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to.

The panel bore in mind, when reaching its decision, that you should be judged by the average standards of a registered nurse and not by any higher or more demanding standard.

The panel considered the NMC guidance, in particular section FTP-2b:

> *‘Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice. Unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse, midwife or nursing associate.’*

Taking into account the reasons given by the panel for the findings of the facts, and with reference to the Code, the panel has concluded that your practice was below the standard that one would expect of the average registered nurse acting in your role.

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of your lack of competence, your fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *‘The question that will help decide whether a professional’s fitness to practise is impaired is:*

“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”
If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

‘In determining whether a practitioner’s fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.’

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's “test” which reads as follows:

‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession'*

The panel determined that both patients and colleagues were put at risk of both physical and emotional harm as a result of your lack of competence.

The panel found that patients were put at risk as a result of your lack of competence, the extent of your failure to achieve the required standards of competence and your attitude towards attempts to help you do so, including your conduct towards other staff members and patients brought the profession into disrepute.

The panel focused on the unprofessional behaviour you presented within the multiple charges found proved. The panel noted that you were on a practice plan in relation to helping you achieve better standards when practicing. However, the panel decided that your conduct towards other staff members, and patients, is found to have been unprofessional.

Therefore, the panel determined that your lack of competence had breached the fundamental tenets of the nursing profession as outlined above within this determination, and therefore, had brought its reputation into disrepute.

The panel was satisfied that the lack of competence in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice or provided any level of insight.

The panel considered the training you have undertaken but noted that this is limited, comprising of online courses at a social care level as demonstrated by the certificates provided, as opposed to training at the level of a registered nurse and does not address all of the areas of concern. However, the panel did consider that your engagement with these courses does represent a level of remediation, albeit, limited. The panel further considered the family letter you provided, which references you having been working successfully in a home care setting as a carer; this, the panel determined, is limited evidence of an attempt/intention to strengthen your practice.

The panel took into account the fact that your case involves multiple concerns, and that you have provided no insight into your lack of competence, nor have you provided a reflective written piece showing insight or acknowledgement into developing/strengthening your practice as a registered nurse (although, the panel did acknowledge your initial reflection which you provided to your previous employer as part of an internal investigation).

The panel considered the context in which you were working within your clinical role at the time of these facts proven. The panel noted the fact that you were providing care as part of a multidisciplinary team, within a new environment. You gave evidence that you had experienced conflict with your colleagues and felt isolated, as though there was a *'conspiracy'* against you.

Consequently, the panel is of the view that there is a risk of repetition based on the fact that you have not provided any significant level of insight or remediation into the seriousness of your actions. The panel noted that there remains a concern in relation to your ability to practice safely, professionally, and kindly, at this stage of this process, as you have not worked in the setting of a registered nurse, nor have you undertaken any specific clinical training aimed at improving your nursing practice. Therefore, there remains a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the ground of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

Given all of the considerations of the panel, it determined that a finding of impairment on public interest ground is also required because a well-informed member of the public would expect a registered nurse facing such concerns relating to your lack of competence, to have your fitness to practice found impaired. In addition, the panel concluded that the public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Mr Smalley noted the following as the aggravating features of this case:

1) The concerns in this case are extensive and wide ranging, despite prolonged support;
2) Patients under your care were placed at risk of harm;

3) The current risk of repetition represents a risk of significant harm to patients;
4) You have provided a lack of/poor insight at this stage of the hearing.

Mr Smalley noted the following as the mitigating feature of this case:

1) Your reflection piece which presents limited insight into your actions.

Mr Smalley submitted that taking no further action or imposing a caution order would be completely inappropriate in this case, due to the public protection concerns identified. Mr Smalley noted that there is a risk of repetition, and therefore, to address the public protection concerns, an order must be imposed which restricts your practice in some form.

Mr Smalley submitted that patients would still be placed at risk if you were allowed to practice even with conditions placed on your practice. Mr Smalley submitted therefore, that the only appropriate order at this stage would be that of a suspension.

Mr Smalley submitted therefore, that the panel should impose a 12-month suspension order.

Dr Akinoshun submitted that the proper approach for the panel at this stage, is to begin by considering the least severe sanction available. He noted that the panel must be proportionate when imposing a sanction and must consider why you are not currently fit to practice, striking a fair balance between your rights, and the public interest.

Dr Akinoshun submitted that the mitigating features in this case, are as follows:

1) You made early admissions to some of the charges at the facts stage of this hearing;
2) You have taken full responsibility for your failings and actions;
3) You have a determination to continue to reflect, learn, and become a better and safe practitioner;

4) You have been practicing competently as a home carer, providing holistic care to a service user since January 2023;
5) You have remained up to date with all relevant training relating to communication, assessing needs, person centred care, information governance, and record keeping;
6) You have engaged fully with the NMC proceedings.

Dr Akinoshun submitted that you have shown evidence of safe practice, albeit as a home carer and have presented no further evidence of risk, or lack of competence. He noted further that you have no previous NMC referrals of this nature.

Dr Akinoshun submitted that the panel must consider the *'background factors',* noting that, you have been placed on an interim conditions of practice order since you were referred to the NMC in 2021. He once again submitted, that you have been unable to secure a job within the nursing setting, and therefore, have not yet been able to address your failings within this specific clinical field.

Dr Akinoshun submitted that a conditions of practice order would have been the preferred sanction today. However, he noted that, a further conditions of practice order on this occasion would not be workable for you, due to your recent struggles in securing employment within any nursing position.

Nevertheless, Dr Akinoshun submitted that the sanction of a 6-month suspension order would be sufficient in the circumstances. He submitted that this order would enable you to address all of the concerns raised by the panel at the impairment stage, whilst also thoroughly reflecting on the relevant findings. Dr Akinoshun submitted that a 6-month suspension order would be sufficient to protect patients and uphold the public confidence in the nursing profession.

[PRIVATE]

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your lack of competence put patients at risk of suffering harm;
- You presented a lack of insight into your failings within the facts found proven;
- Your lack of competence was not a single incident of concern, but were wide ranging in nature;
- Your lack of competence occurred over a period of time and impacted both patients and your colleagues;

The panel also took into account the following mitigating features:

- You have shown some insight and remediation into the concerns relating to your communication skills. Your current employer has stated that your communication is *'clear and concise'*;
- Your perception was that you were both isolated and unsupported within your previous work setting in which the proven charges occurred.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular, that conditions may be appropriate where:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*

The panel determined that conditions would be inappropriate in this case. In the absence of full reflection and insight into the wide-ranging competency issues, the panel were concerned about your willingness to respond positively to retraining.

The concerns identified in the facts found proved are serious involving risks to people receiving care. The panel are of the view that your behaviour was particularly serious as your conduct and poor practice indicated a dangerous attitude to the safety of people receiving care. The panel have had regard to the context in which concerns arose and your attitude toward colleagues and patients at that time and the panel also bore in mind the fact that concerns arose when you were subject to an improvement plan. Notwithstanding that the concerns around

your clinical practice are wide ranging, the panel are currently of the view that those concerns may be capable of remediation. However, your insight into the concerns has been very limited and until you have demonstrated proper insight regarding the concerns and your own practice, and taken steps to improve your nursing practice, the risk to public safety remains high. Until the issues around your insight have been addressed there are no workable conditions of practice which would be appropriate to address the concerns around your clinical practice at this time.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of the charges found proved and would not protect the public.

The panel therefore concluded that the only appropriate order to address public protection is a suspension order and we are also of the view that a suspension order is required in the public interest to maintain public confidence in the profession as the public would be concerned to know that a nurse would be allowed to practice until the concerns have been addressed.

The panel determined that your lack of competence in the charges found proved are wide ranging, both in nature and over a period of time. The panel further highlighted that both patients and your colleagues were put at a risk of harm due to your lack of competence; you have presented a lack of insight, appropriate training, and reflection, which therefore

results in a significant risk of repetition in this case. The panel determined that a period of suspension would be a proportionate sanction to protect the public and to mark the seriousness of your lack of competence.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 6 months was appropriate in this case to mark the seriousness of the lack of competence, alongside allowing you the time to develop and evidence your insight and reflect on your lack of competence.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Evidence of insight and remorse into your failings;
- Evidence that you have refreshed your professional knowledge and any other evidence that you may want to provide as evidence of having strengthened your practice;
- Any references/testimonials provided by either paid or unpaid work;
- An updated reflective piece in response to the facts found proved in this case.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Mr Smalley submitted that an interim suspension order for a period of 18 months should be imposed in order to cover any possible appeal period.

Dr Akinoshun submitted that you are indifferent to the application made by Mr Smalley.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to cover any possible appeal period which may arise.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after you is sent the decision of this hearing in writing.

That concludes this determination.