Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 9 January 2024 – Friday, 12 January 2024
Monday, 22 January 2024 – Friday, 26 January 2024
Monday, 15 April 2024 – Tuesday, 23 April 2024
Monday, 19 August 2024 – Tuesday, 20 August 2024
Friday, 23 August 2024
Monday, 9 September 2024 – Wednesday, 11 September 2024

Virtual Hearing

Name of registrant:	**Yosi Daniel Akut**
NMC PIN:	99D1370O
Part(s) of the register:	Registered Adult Nurse – Sub part 1 RN1: Level 1 (23 April 1999)
Registered location:	Edinburgh
Type of case:	Misconduct/Lack of competence
Panel members:	Avril O'Meara (Chair, lay member) Kim Bezzant (Registrant member) Frances McGurgan (Lay member)
Legal Assessor:	Michael Hosford-Tanner (9-12, 22-26 January 2024) Jayne Wheat (15-23 April 2024, 19, 20, 23 August 2024) Marian Killen (9-11 September 2024)
Hearings Coordinator:	Sherica Dosunmu (9 January 2024) Samantha Aguilar (11 January 2024) Clara Federizo (10-12, 22-26 January 2024, 15-23 April 2024 and 9-11 September 2024) Stanley Udealor (19, 20 and 23 August 2024)
Nursing and Midwifery Council:	Represented by Lucie Danti, Case Presenter
Mrs Akut:	Present and represented by Adewuyi Oyegoke

Admitted charges:	Charges 1, 2c(i), 2c(ii), 2d, 2f, 2g, 2h, 2i, 2j, 2k,2l, 3a(i)-(iv), 3b, 3c, 3d, 3e, 3f, 4, 5, 11a, 11b, 11c, 14a, 14b, 15 and 16
Offering no evidence:	Charges 12a, 12b and 13
No case to answer:	Charges 2b and 10
Facts proved:	Charges 2a, 6a, 6b, 7, 8a, 8b, 9 and 14c
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to amend the charges on day 1

The panel heard an application made by Ms Danti, on behalf of the Nursing and Midwifery Council (NMC), to amend charges 2c(ii), 2e, 2k, 3b, 3c, 3d, 3e, 4 and 12 under Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004' as amended (the Rules).

Ms Danti referred the panel to charges 2e and 2i. She explained that charge 2e is a repetition of charge 2i and the proposed amendment is to remove charge 2e as a duplicate. Additionally, Ms Danti highlighted that there are grammatical errors in charges 2c(ii), 2k, 3b, 3c, 3d, 3e and 4, which would require minor changes to the wording of each charge.

Ms Danti also referred the panel to charge 12. She proposed to change the date from '*10 April 2019*' to '*12 April 2019'.* She submitted that it is apparent from the evidence in this matter that the date in charge 12 is incorrect, and the proposed amendment would more accurately reflect the evidence.

Ms Danti submitted that overall, the proposed amendments only relate to grammatical and administrative errors. She submitted that such amendments would ensure accuracy and would not cause prejudice or injustice to you.

Mr Oyegoke, on your behalf, indicated that he did not object to any of the proposed amendments.

<u>Proposed amendments:</u>

"[…]

2) While subject to an informal capability process you:

…

c) On 2 December 2018 in respect of an unknown patient:

i) …

ii) Failed **to** identify and/or document **that** their elbow was swollen.

…

~~e) On or around 10 April 2019 during moving and handling of a patient you drag lifted an unknown patient up the bed.~~

…

k) On **a** date unknown left an unknown patient on the toilet who was at high risk of falls.

…

3) Between 29 July 2019 and 20 August 2020 whilst subject to an Informal Capability Action Plan you:

…

b) On or around 17 October 2019 failed to complete **a** risk assessment on delirium and impairment for an unknown patient.

c) On or around 17 October 2019 failed to complete **an** infection prevention assessment for **an** unknown patient.

d) On or around 17 October 2019 failed to complete **a** Malnutrition Universal Screening Tool ("MUST") assessment for an unknown patient within 6 hours of admission.

e) On or around 17 October 2019 failed to complete **a** Waterlow (Pressure Area Risk Assessment Chart) within 6 hours of admission for an unknown patient.

…

4) Between 1 September 2018 and 29 July 2019 did not ~~to~~ complete an accountability workbook when requested to do so by Nurse A.

[…]

12) On ~~10~~ **12** April 2019;

a) …

b) …"

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such amendments did not change the nature or gravity of the charges against you. On the basis that there has been no objection to the proposed

amendments, the panel was also satisfied that there would be no prejudice to you and no injustice would be caused to either party. The panel determined that it was therefore appropriate to allow the amendments above, to ensure clarity and accuracy.

Decision and reasons on application to amend the charges on day 3

On day 3 of the proceedings, the panel heard a further application from Ms Danti to amend the wording of charges 6b, 8a, 8b and 9. The proposed amendments for charges 6b, 8a, 8b and 9 are as follows:

"[…]

6. On 9 December 2018 in respect of Patient A:
    a) …
    b) Incorrectly told ~~Nurse A,~~ Nurse ~~B~~ **C** and Nurse D that you had not touched the Syringe Driver pump when you were asked.

[…]

8. On ~~23~~ **24** December 2018 having been ~~asked~~ **told** by Nurse A **on 22 December 2018 that Nurse E would discuss** ~~to bring and/or have available your~~ **the** accountability ~~booklet~~ **workbook with you**;
    a) ~~Did not bring and/or have available your accountability booklet for discussion with Nurse E.~~ **Refused to discuss the accountability workbook with Nurse E.**
    b) Incorrectly told Nurse E that **Nurse A had not told you the** ~~you had not been asked to bring your~~ accountability ~~booklet~~ **workbook would be discussed.**

9. Your actions at charge 8b above were dishonest in that you knew Nurse A had ~~requested~~ **told** you **that Nurse E would be discussing the accountability workbook with you** ~~bring your accountability booklet for discussion~~."

Ms Danti submitted that in respect of the evidence that has come to light, in particular, the audio recording provided by you and the oral evidence of Nurse A, an application should be made in respect of charge 6b to remove *'Nurse A'*. Ms Danti submitted that there would be no injustice caused to either party and that the substance of the charge remained the same, and "*crucially, so does the seriousness of the charge*". Also, Ms Danti submitted that Nurse B was referenced in the main evidence bundle as Nurse C and although it was clear to you and the NMC who this individual is, the panel might be minded to amend the charge to reflect the evidence in the bundle. Ms Danti submitted there was no injustice in making such an amendment. It was required to ensure that the charge accurately reflects the evidence and it is clear to the panel who the individual is.

In respect of charges 8a, 8b and 9, Ms Danti submitted that the charges relate to *"not engaging with the process of filling in the accountability workbook"* and that the fundamental substance of the charges remained *"entirely the same"*. She submitted that her proposed new charges would reflect the evidence contained within the audio file that was only disclosed last week.

Ms Danti submitted that had the audio recording been brought to the attention of the NMC sooner, the amendments proposed would have been made at an earlier stage. The dishonesty and the misconduct that the NMC are concerned with is alleged that you knew that you were supposed to discuss the accountability workbook with Nurse E.

Ms Danti addressed the issue of fairness. She reminded the panel that fairness *"cuts both ways and is required to be considered in respect of the NMC and the Registrant".* She submitted that the level of seriousness remains entirely the same and that no prejudice would be caused to you as a result of the proposed amendments, as you have been in possession of the recording for years and have chosen not to disclose it until very recently.

Mr Oyegoke submitted that in respect of the proposed amendment to charge 6b, of *'Nurse B'* to *'Nurse C'*, that you have been aware since the outset who this individual is and there is no objection to making this amendment.

Mr Oyegoke submitted that he strongly opposed the NMC's application to the other proposed amendments to charges 8a, 8b and 9 at this stage of the hearing, because the amendments submitted by the NMC are unfair to you and made at a very late stage. He told the panel that the main purpose of the NMC is for the protection of the public and to *"equip"* the nurse with an understanding of the legal limits of their actions and the consequences.

Mr Oyegoke told the panel that allowing the amendments is serious as the charges are connected with an allegation of dishonesty. He told the panel that he wholly disagreed with the manner in which the NMC set out their case at this late stage. He submitted that changing the wording in charge 8a and charge 8b from *'bring'* to *'discuss'* was not merited as it did not relate to behaviour in *"a clinical setting".* He submitted that there are ways that the panel can deal with the matters relating to the accountability booklet which would in no way increase the severity of the charges that you faced. If the application were approved, it would require the recalling of Nurse A.

Mr Oyegoke also submitted that allowing such amendments after a witness has given their evidence would be unfair and that witness would need to be recalled. He submitted that it was too late in proceedings to amend these charges and to allow this would cause significant injustice to you.

Ms Danti responded to Mr Oyegoke's submission and submitted that, in respect of Nurse A being recalled after providing evidence, Nurse A had been *"crystal clear"* in her evidence about the conversation that she had with you regarding completing the workbook on 24 December 2018. Further, she submitted that Nurse A was very clear that she was not suggesting that you have been dishonest and that such a suggestion would have been

inappropriate, as it is for the panel to determine any charges of dishonesty. Nurse A's purpose as a witness was to present the facts and her evidence.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that the amendments to charge 6b, as applied for, were 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 amendments being allowed. The panel noted Nurse A's evidence that she was not working on 10 December 2018. It also noted that Mr Oyegoke did not have any objection to amending the charge to reflect that Nurse C was the relevant individual. The panel noted that Mr Oyegoke and you were aware of who this individual was, and the substance of the charge remained the same. The panel determined it was therefore appropriate to allow the amendments, as applied for, to better reflect the evidence in respect of charge 6b.

The panel carefully considered the application to amend charges 8a, 8b and 9. It recognised that the existence and late submission of the audio recording has had an impact on these charges. It accepted that the alleged mischief in these charges is in relation to you not engaging in discussions with Nurse E regarding the accountability workbook, having been told by Nurse A to do so, on 24 December 2018. It is now clear from the audio recording and evidence of Nurse A that you did not have the booklet in your possession on 24 December 2018.

The panel accepted that it is not ideal to amend the charges after the witness evidence has started and acknowledged that there is a risk that a witness has to be recalled. However, it considered that Nurse A's evidence concerning the need for you to go through the booklet with Nurse E was consistent with the audio recording you produced. The panel noted that Nurse E, the other witness in relation to this charge has yet to give oral evidence. The panel bore in mind that it has discretion to amend the wording of the charges before making its findings of fact. It noted that Mr Oyegoke has the opportunity to

cross examine subsequent witnesses to challenge their oral evidence, that Nurse A can be recalled if necessary, and that the persuasive burden still lies with the NMC.

In considering the overall merit and fairness, the panel decided that given that charges 8a, 8b and 9 relate to allegations of dishonesty, the panel was of the view that it is fair to amend these charges to explore whether or not the allegations are true or not. Although the substance of the charges has changed, the panel was satisfied there was no change in the nature of the alleged mischief or the seriousness of the charges. The audio recording supports the suggestion that you were to *'go through'* the workbook with Nurse E on 24 December 2018, although the workbook was not given to you in advance by Nurse A. The panel determined that no injustice would be caused to you in allowing the amendment and decided it was fair to allow the amendments in respect of charges 8a, 8b and 9.

Decision and reasons on a further application to amend charge 6

During the course of the proceedings, Ms Danti made a further application to amend charge 6. The proposed change was only a matter of date correction as opposed to any change to the substance of the charge. She submitted this was a minor correction to accurately reflect the evidence and in the interest of justice. She submitted that this amendment will not cause any prejudice to you by this being allowed.

The proposed amendment is as follows:

"[…]

2) On ~~9~~ **10** December 2018 in respect of Patient A:

a) …

b) …"

Mr Oyegoke submitted that there is no objection to this application.

The panel took into account the submissions made by Ms Danti and noted that this was not contested by Mr Oyegoke. It therefore determined that there would be no unfairness towards you in allowing this amendment for the purpose of more accurately reflecting the evidence before it. This application was granted and changes were applied to the charge.

Details of charges (as amended)

That 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 you:

1) Between 1 September 2018 and May 2019 on one or more occasions provided care to patients on your own when they required two members of staff to assist. **[ADMITTED]**

2) While subject to an informal capability process you:
   a) On 21 November 2018 you rushed an unknown patient to eat. **[PROVED]**
   b) On or around 21 November 2018 you were unable to feedback and/or verbalise the care required for two patients. **[NO CASE TO ANSWER]**
   c) On 2 December 2018 in respect of an unknown patient:
      i) Failed to carry out a skin inspection. **[ADMITTED]**
      ii) Failed to identify and/or document that their elbow was swollen. **[ADMITTED]**
   d) On 3 December 2018 failed to communicate with a patient when you were moving them following a fall. **[ADMITTED]**
   e) …
   f) On or around 10 April 2019 rushed and/or were rough with an end-of-life patient when assisting her to the toilet. **[ADMITTED]**
   g) On 17 April 2019 failed to explain to an unknown patient that you were going to move her arm prior to injecting her with insulin. **[ADMITTED]**
   h) On 17 April 2019 had to be prompted and/or were unable to use the control for a hospital bed. **[ADMITTED]**

i) On 12 April 2019 failed manual handling training in that you while repositioning an unknown patient handled them underarm/under their shoulder joint. **[ADMITTED]**

j) On 26 April 2019 in respect of an unknown deceased patient had to be prompted not to remove a urinary catheter until death had been verified. **[ADMITTED]**

k) On a date unknown left an unknown patient on the toilet who was at high risk of falls. **[ADMITTED]**

l) On a date unknown were unable to explain and/or use a falls monitor. **[ADMITTED]**

3) Between 29 July 2019 and 20 August 2020 whilst subject to an Informal Capability Action Plan you:

a) When given a scenario where a patient had placed a cord wrapped around their neck you were unable to explain that you should:

i) Talk to the patient; **[ADMITTED]**

ii) Remove the cord from the patient's neck; **[ADMITTED]**

iii) Datix the incident; **[ADMITTED]**

iv) Undertake an anti-ligature assessment. **[ADMITTED]**

b) On or around 17 October 2019 failed to complete a risk assessment on delirium and impairment for an unknown patient. **[ADMITTED]**

c) On or around 17 October 2019 failed to complete an infection prevention assessment for an unknown patient. **[ADMITTED]**

d) On or around 17 October 2019 failed to complete a Malnutrition Universal Screening Tool ("MUST") assessment for an unknown patient within 6 hours of admission. **[ADMITTED]**

e) On or around 17 October 2019 failed to complete a Waterlow (Pressure Area Risk Assessment Chart) within 6 hours of admission for an unknown patient. **[ADMITTED]**

f) On or around 17 October 2019 on one or more occasions failed to complete risk assessments for unknown patients within the 24-hour timeframe. **[ADMITTED]**

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence.

That you, a registered nurse:

4) Between 1 September 2018 and 29 July 2019 did not complete an accountability workbook when requested to do so by Nurse A. **[ADMITTED]**

5) Between 1 September 2018 and 29 July 2019 on more than one occasion shouted at an unknown patient. **[ADMITTED]**

6) On 10 December 2018 in respect of Patient A:
   a) Failed to inform the nurse in charge that you had paused their syringe driver. **[PROVED]**
   b) Incorrectly told Nurse C and Nurse D that you had not touched the Syringe Driver pump when you were asked. **[PROVED]**

7) Your actions at charge 6b were dishonest in that you knew that you had paused the pump. **[PROVED]**

8) On 24 December 2018 having been told by Nurse A on 22 December 2018 that Nurse E would discuss the accountability workbook with you:
   a) Refused to discuss the accountability workbook with Nurse E **[PROVED]**
   b) Incorrectly told Nurse E that Nurse A had not told you the accountability workbook would be discussed. **[PROVED]**

9) Your actions at charge 8b above were dishonest in that you knew Nurse A had told you that Nurse E would be discussing the accountability workbook with you. **[PROVED]**

10) On 7 January 2019 shouted at Nurse A. **[NO CASE TO ANSWER]**

11) On 26 February 2019:
    a) on one or more occasions shouted at Nurse A. **[ADMITTED]**
    b) acted in an aggressive manner towards Nurse A; **[ADMITTED]**
    c) refused to leave when requested to do so by Nurse A. **[ADMITTED]**

12) On 12 April 2019:
    a) failed to fully check an unknown patient's incontinence pad.**[NO EVIDENCE]**
    b) Signed the unknown patient care rounding stating the incontinence pad was clean and dry. **[NO EVIDENCE]**

13) Your actions at charge 12b above were dishonest in that you knew you had not adequately checked the incontinence pad. **[NO EVIDENCE]**

14) On 26 April 2019 you:
    a) Acted in an aggressive manner towards Nurse A; **[ADMITTED]**
    b) On one or more occasions shouted and/or screamed at Nurse A. **[ADMITTED]**
    c) Shouted at Nurse A that she "would be struck down by god" or words to that effect. **[PROVED]**

15) On 1 October 2019 failed to administer to Patient B pain relief medication, "Oramorph". **[ADMITTED]**

16) On or around 21 October 2019 shouted at Nurse B. **[ADMITTED]**

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

Decision and reasons on application to admit hearsay evidence relating to charges 12 and 13

The panel heard an application made by Ms Danti under Rule 31 to allow the written witness statement of Ms 1 into evidence, paragraph 64 of Nurse A's witness statement and relevant exhibit. Ms 1 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. She submitted that there is good reason for Ms 1 not to attend [PRIVATE], and there is no duty upon her to attend such proceedings in her role as a healthcare support worker.

Ms Danti submitted that the evidence from Ms 1 is relevant as it speaks to charges 12 and 13 and is not sole or decisive, as this can be confirmed and/or challenged when Nurse A provides oral evidence to the panel. She also submitted that there is no objection to the relevant exhibit as this is recorded in the case management form and there are no reasons for Ms 1 to fabricate any evidence. Further, she submitted that you did have prior notice that the witness statements were likely to be read and you were provided with this information prior to the hearing. Ms Danti submitted that for all the above reasons, it is therefore fair and relevant to admit this hearsay statement into evidence.

With respect to the application, Mr Oyegoke submitted that it is not fair to admit the hearsay evidence produced by Ms 1. He highlighted an email response, dated 5 July 2023, from Ms 1 to the NMC's request for a signature for the witness statement, which states:

> *"…As I said on the phone previously, I have no recollection of this and none of the dates add up so I'm not happy to sign any paperwork. I will not be attending any hearing so I guess you could just withdraw my statement."*

Mr Oyegoke submitted that such evidence cannot be taken any further. He submitted it is not relevant nor fair to admit given Ms 1 herself has requested that her statement be withdrawn and it is not evidence supported by Ms 1. He added that the witness statement before the panel remains unsigned. Further, in relation to the allegation of dishonesty, he submitted that no other charges as such were admitted. He submitted that you had not been made aware of the information regarding the correspondence, dated 5 July 2023, between Ms 1 and NMC, until very recently. He submitted that for the reasons above, this application should be rejected.

In response, Ms Danti submitted that the NMC are not required to disclose emails received in the course of correspondence in advance of the hearing. She stated that this information has now been disclosed as part of a hearsay application, which was only produced in the last 24 hours because your position in relation to the admission of certain charges had recently changed. She submitted that the panel may consider that the hearsay statement is a local statement made at the time and is contemporaneous 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 referred to the cases of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), *El Karout v NMC* [2019] EWHC 28 (Admin), *Mansardy v NMC* [2023] EWHC 730 (Admin).

The panel was of the view that the evidence produced by Ms 1 was directly relevant as it relates to charges 12b and 13. The panel noted that Ms 1's evidence regarding charge 12a was double hearsay as she was not a direct witness to the alleged events and was reporting to other members of staff what others had told her.

In respect of fairness, the panel determined that it was not fair to admit this evidence. Although the panel noted that the NMC had made efforts to ensure the attendance of Ms

1, it recognised she is not a registered nurse therefore there is no duty on her to attend. Further, there is information before the panel which indicates that Ms 1 refused to sign her statement, requested for it to be withdrawn and does not want to take part in the hearing. It also considered that Ms 1 states that she does not remember the events. The panel considered that in light of all the evidence, Ms 1 does not support her statement and it therefore, determined that the evidence was not demonstrably reliable. The charges allege dishonesty and the reasons for Ms 1 refusing to sign the statement, which had been drafted for her, should have been disclosed to you at the earliest opportunity and not during the hearing. In these circumstances, the panel refused the application.

Decision and reasons on application to admit hearsay evidence of Nurse D in relation to charges 6a, 6b and 7

The panel heard another application made by Ms Danti under Rule 31 to allow the written statement of Nurse D and relevant exhibits into evidence. Ms Danti regrettably informed the panel that Nurse D was not present at this hearing [PRIVATE]. She submitted that her evidence is highly relevant, particularly to charges 6a, 6b and 7, which are serious.

Ms Danti submitted in regard to fairness, that Nurse D's evidence is not sole nor decisive as Nurse C is also providing oral evidence to the panel, which can support the more fundamental elements of the alleged charges and she can be cross-examined. Further, Ms Danti submitted that there is no evidence to suggest that Nurse D would have fabricated evidence against you. She submitted that Nurse D's evidence is only corroborative and provides context to the alleged charges and added that the panel may consider what weight to attach to it at a later stage. She submitted there is no unfairness to you in allowing this evidence to be admitted and invited the panel to accept the application.

With respect to the application, Mr Oyegoke submitted that although the panel may find the evidence of Nurse D to be relevant, it would be unduly unfair to you to admit evidence which cannot properly be cross-examined given that you firmly deny these allegations.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application.

The panel gave the application in regard to Nurse D serious consideration. The panel noted that Nurse D's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* and was signed by her.

The panel determined that the evidence was highly relevant as it speaks to specific allegations, these alleged charges were serious, and Nurse D was a direct witness of the events and was the person in charge of the unit. It noted that the evidence was signed, dated and contemporaneous.

In terms of fairness, the panel determined that this evidence was not the sole or decisive evidence in relation to the charges as the panel will hear oral evidence from Nurse C. It also considered that there was no information to suggest that Nurse D had any reason to fabricate evidence, and although the panel noted Mr Oyegoke's submission that you were not aware until recently that [PRIVATE], there is understandably a reason for her non-attendance.

The panel considered that you had been provided with a copy of Nurse D's statement in advance and there was also a public interest in the issues being explored fully and this supported the admission of this evidence into the proceedings. The panel considered that any unfairness in this regard was limited and worked both ways, in that both the NMC and the panel were also deprived of reliance upon the live evidence of Nurse D and the opportunity of questioning and probing that testimony.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Nurse D and it would give what weight it deemed appropriate once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to offer no evidence

The panel considered an application from Ms Danti to offer no evidence in respect of charges 12a, 12b and 13.

In relation to this application, Ms Danti submitted that following the panel's earlier decision not to admit hearsay evidence in relation to Ms 1, the NMC offers no evidence in respect of charges 12a, 12b and 13, which Ms 1's evidence related to. She submitted that it is not in the public interest for the NMC to pursue factual charges against a nurse if there is not enough evidence to prove the facts or if the charge relies on the evidence of a witness who cannot attend the hearing. She submitted that the evidence of Ms 1 was the sole and decisive evidence in respect of charges 12 and 13. She invited the panel to accept that the NMC are offering no evidence because there is no longer a realistic prospect that the facts will be found proved.

Mr Oyegoke did not oppose the application.

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. It took into account the submissions made by Ms Danti, which Mr Oyegoke did not oppose.

The panel noted that the majority of charges are admitted, and these relate to lack of competence and misconduct. It noted that the dishonesty allegations are not admitted anywhere else. 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 charges 12a, 12b and 13 proved. The panel was also satisfied there is no realistic prospect of other evidence being obtained in relation to these charges.

The panel acknowledged that the public interest does require the panel and the NMC to consider whether the matter should be explored further but does not require the NMC to pursue factual allegations where there is no realistic prospect of success. As to whether charges 12 and 13 even if proved, would add significantly to the overall seriousness of the case, the panel took into account the charges you have already admitted and accordingly, determined that it would not.

The panel allowed the application to offer no evidence in respect of charges 12a, 12b and 13 as the NMC offer no evidence in this regard.

Decision and reasons on a further application to admit hearsay evidence of Ms 2 in respect of charge 2a

The panel heard a further application made by Ms Danti under Rule 31 to allow the written statement of Ms 2 into evidence.

Ms Danti referred the panel to relevant case law, NMC guidance and took the panel through factors it may take into account. She acknowledged that the charge is serious and if found proved, there could be adverse effects on your career. However, she submitted that Ms 2's evidence is not the sole or decisive evidence in support of the charge as the panel has had documentary evidence and heard oral evidence from Witness 4. She submitted that the other witness has been cross-examined and that the evidence of Ms 2 is merely corroborative and provides context to the charge.

Regarding the nature and extent of the challenge to the contents of Ms 2's evidence, Ms Danti referred the panel to the Case Management Form (CMF) completed by Mr Oyegoke on your behalf. She explained that the form outlines the documents that the NMC will rely on, which included the written statement of Ms 2 along with Witness 4's references as exhibit *'LC/6'*. She highlighted that the column next to it states: *"If you don't want the panel to see this document, please tell us why"* and submitted that having not filled out the

column, you did not raise any objections to the statement being put before the panel. She submitted that having signed the CMF, you confirmed that you understand and have taken into account everything within it. She submitted that it was always clear that Ms 2's statement was going to be placed before the panel, that you and Mr Oyegoke have received all the documents in the exhibit bundle, and an opportunity was given to you to object to any part of it.

Ms Danti submitted that at the time of investigation of this case, Ms 2 [PRIVATE] and the NMC decided it was not appropriate to approach her for a witness statement. [PRIVATE]. Whilst she could have been contacted after August 2023, a decision was made by the NMC that this was not a proportionate measure to take given that Ms 2's evidence was not the sole or decisive evidence in respect of charge 2a, as the evidence of Witness 4, who was also a direct witness to the incident had been obtained. Ms Danti further submitted that there was no suggestion that Ms 2 had any reason to fabricate her evidence.

For all the reasons set out above, Ms Danti submitted that it is relevant and fair to admit the local statement of Ms 2 as hearsay evidence.

In response, Mr Oyegoke opposed the application and submitted that it would not be fair to admit Ms 2's hearsay evidence. He submitted that the NMC did not satisfy the principles in *Thorneycroft.* He submitted that the NMC should have taken reasonable steps to ensure the attendance of Ms 2, and whilst this was not a requirement, there was not a good reason as to why this witness was not present to give evidence at this hearing. He submitted that the NMC had had an opportunity to do so since August 2023. Further, he submitted that you would be disadvantaged by Ms 2's non-attendance as there would not be opportunity for cross-examination. He submitted that allowing Ms 2's statement into evidence would be unfair to you, as the fact in question is disputed.

The panel heard and accepted the legal assessor's advice on the matters it should take into consideration in respect of this application.

The panel gave the application in regard to Ms 2 serious consideration. The panel considered that Ms 2's evidence was not sole or decisive for charge 2a as there was evidence from other witnesses that supported the charge. The panel took into account that Witness 4 was a direct witness of the alleged events. Also, it took into account that Nurse A was the senior charge nurse, who provided evidence that Witness 4 and Ms 2 had complained to her promptly and that they had provided statements at the time at her request. Both Witness 4 and Nurse A were cross-examined and their evidence challenged in relation to the alleged event.

The panel determined that Ms 2's evidence is capable of being corroborative but it is not the sole or decisive evidence. It also noted that Ms 2's local statement contained the sentence *'This statement is true to the best of my knowledge'* and was signed and dated by her.

The panel noted that the evidence was not initially challenged on the CMF which was completed and signed by Mr Oyegoke. However, it recognised that this evidence is now objected to.

The panel acknowledged Mr Oyegoke's submission that Ms 2 cannot be cross-examined and therefore this would be a disadvantage to you. It assessed the reason for Ms 2's non-attendance and concluded that the NMC had not taken sufficient steps to ensure Ms 2's attendance. In addition, the panel considered that the NMC should have informed you and your representative of the reason for the NMC not attempting to obtain a witness statement from Ms 2, when the NMC had taken that step in relation to Witness 4. The panel did not attach importance to the fact that no objection was raised by your representative (when signing the CMF in December 2022) to Ms 2's local statement remaining in the exhibit bundle, as it was not consent given with full knowledge of the facts concerning Ms 2.

The panel took account that Ms 2's local statement covered the same matters and arose in identical circumstances to the local statement of Witness 4, who has attended and been

cross-examined. It noted that both internal statements had been disclosed to you before the CMF of December 2022. The panel came to the view that it was plainly relevant, and also it would be fair to accept into evidence the written statement of Ms 2 and it would give what weight it deemed appropriate once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Oyegoke, on your behalf, that there is no case to answer in respect of charges 2b and 10. This application was made under Rule 24(7).

In relation to this application, Mr Oyegoke referred to relevant case law. He submitted that the oral evidence from Nurse A suggests that she was not at work on 7 January 2019. Therefore, the allegation is not established as there is no evidence to support it, in fact it contradicts it. He also submitted that there is no evidence from Nurse A's three witness statements or the exhibit bundle to support the charge. He submitted that charge 10 should not be allowed to remain before the panel.

In relation to charge 2b, Mr Oyegoke submitted that although there is some evidence to support this charge, the evidence is tenuous. He submitted that Nurse A's witness statements do not mention anything about this incident. He submitted that information relating to this charge can be found in Nurse A's Informal Capability Process Timeline, dated 21 November 2018. He submitted that this evidence was double hearsay as Mr 3 was working with you and not Nurse A, that there is no evidence of a discussion between Mr 3 and Nurse A, and it is not mentioned at all in Nurse A's oral or written evidence. He submitted that the evidence the NMC relies on in support of this charge is weak and tenuous and that the NMC had not discharged the burden of proof.

In these circumstances, Mr Oyegoke submitted that charge 2b should not be allowed to remain before the panel.

Ms Danti submitted that the panel are to consider whether there is sufficient evidence so that a properly directed panel could find a charge proved. It must not consider the weight of evidence at this stage. She submitted that it is a high bar for the panel to be satisfied that there is no case to answer.

Ms Danti informed the panel that the NMC were not making any submissions in respect of charge 10.

In respect of charge 2b, Ms Danti submitted that the exhibit referred to by Mr Oyegoke (the Informal Capability Process Timeline) is an exhibit produced by Nurse A and accepted by the panel to be her evidence in chief. She submitted that the fact the information does not appear in Nurse A's witness statement does not detract from the fact that the exhibit is evidence said to be in support of the charge. She submitted that the evidence is of an 'informal capability process timeline', which shows what you were being tasked to do in relation to issues raised. Ms Danti submitted that, in Nurse A's oral evidence, she clarified that this was supposed to be *'feedback'*, she explained what she expected you to do as part of your action plan and that she had not received any vocalized intentions, at the time of writing her timeline. Ms Danti submitted that there is sufficient evidence, taken at its highest, that could result in a properly directed panel to find the facts proved in charge 2b.

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.

Charge 10

The panel noted that the NMC had no submissions to make in opposition to your application of no case to answer. The panel carefully considered all the documentary and oral evidence before it. It noted that Nurse A's written statements and exhibits do not contain information to support the charge and Nurse A's oral evidence was that she *"probably wasn't there on 7 January 2019".* Therefore, 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 10 proved and it would not be safe to do so on the present evidence.

Charge 2b

The panel considered all the documentary and oral evidence before it. It had regard to the exhibit of the informal capability process timeline, which outlined what Nurse A expected you to do whilst subject to an informal capability process.

In considering Nurse A's oral evidence, the panel noted that Nurse A stated that you did not feedback and/or verbalise the care required for two patients by 14:15, which was at the time of Nurse A's writing of her note. Nurse A confirmed in her oral evidence that it was possible that you had completed this task after Mr 3 had fed back to her at 14:15, as your shift did not end until 16:30.

The panel also noted that the evidence suggests that Mr 3 was responsible for getting the feedback referred to in charge 2b and recognised that Mr 3 was not in attendance at this hearing and the NMC did not provide any evidence from Mr 3 in support of this charge. The panel was satisfied that the evidence that you were *'unable'* to complete the task on or around 21 November 2018 was weak and tenuous. The panel determined that there was not a realistic prospect that it would find the facts of charge 2b proved and it would not be safe to do so on the present evidence.

The panel therefore found no case to answer in respect of charge 10 and charge 2b.

Background

You were referred to the NMC on 11 August 2020 by the Deputy Chief Nurse at NHS Lothian (the Trust). At the time of the alleged concern, you were working as a Band 5 nurse at the Trust.

In September 2018, you were moved to Filleside Ward (the Ward) following [PRIVATE]. During your time on the Ward, you were line managed by Nurse A. In October 2018, concerns were raised regarding your general competence as a Band 5 nurse. An informal action plan was put in place on 22 October 2018.

Throughout November 2018, further concerns were raised regarding your practice. These were that you allegedly:

- were seen rushing a patient during feeding and shoving big spoonfuls of food into their mouth.
- were unable to delegate tasks.
- were unable to carry out risk assessments.
- were unable to demonstrate clinical judgement.

In December 2018 and January 2019, further concerns were noted. These were that you allegedly:

- failed to carry out a skin inspection of a patient and identify and/or document that their elbow was swollen.
- failed to communicate with a patient when moving them following a fall.
- provided care for patients on your own when they required two members of staff to assist them.
- were seen shouting at a patient.
- paused a patient's syringe driver but did not inform the nurse in charge.
- failed to fully check a patient's incontinence pad and documented they were clean and dry when they were not.

On 26 February 2019, you were given an action plan which you were required to complete.

In April 2019, it is alleged that you were not making meaningful progress with your action plan and concerns were still being identified with your practice. These were that you allegedly:

- were rough with and/or rushed an end-of-life patient whilst you were assisting them going to the toilet.
- failed to explain to a patient that you were going to move her arm prior to injecting her with insulin.
- had to be prompted and/or were unable to use the control for a hospital bed.
- you failed manual handling training.
- in respect of a deceased patient had to be prompted not to remove a urinary catheter until death had been verified.

On 26 April 2019, a formal capability meeting was held. You were informed that your capability programme was being extended. You allegedly became aggressive towards Nurse A and started shouting and screaming at her.

You were moved to a non-clinical role on 7 May 2019.

In July 2019, you were moved back to a clinical role on Rowan Ward (‘Rowan’) and predominantly cared for frail elderly patients. You were recommenced on the same capability programme that you were on during your time on the Ward.

Whilst on Rowan you passed your medication competency on 15 October 2019, however, there were still a number of other concerns with your practice. These were that you allegedly:

- failed to give a patient’s pain relief.
- failed to complete certain risk assessments and admission paperwork for patients.

- failed to demonstrate the standards of knowledge, skill, and judgement required to practice without supervision as a Band 5 nurse.

In October 2019, you were absent from work [PRIVATE]. You never returned to the Trust. You resigned in August 2020.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Oyegoke, who informed the panel that you made full admissions to charges 1, 2c(i), 2c(ii), 2d, 2f, 2g, 2h, 2i, 2j, 2k,2l, 3a(i)-(iv), 3b, 3c, 3d, 3e, 3f, 4, 5, 11a, 11b, 11c, 14a, 14b, 15 and 16.

The panel therefore finds the aforementioned charges proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Danti and Mr Oyegoke.

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 (Nurse A): [PRIVATE];

- Witness 2 (Nurse C): [PRIVATE];

- Witness 3 (Nurse E): [PRIVATE];

- Witness 4: [PRIVATE].

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 2a)

> *"While subject to an informal capability process you:*
>
> *a) On 21 November 2018 you rushed an unknown patient to eat."*

This charge is found proved.

In reaching this decision, the panel had particular regard to the written and oral evidence of Nurse A and Witness 4, as well as your evidence, and the hearsay evidence of Ms 2.

The panel had regard to the evidence produced by Nurse A, her oral evidence and your evidence and established that you were subject to an informal capability process during November 2018. The panel heard oral evidence from Nurse A that [PRIVATE] (Ms 2 and Witness 4), reported to her independently their concerns regarding the way in which you fed a patient on the Ward on 21 November 2018.

The panel considered the oral evidence of Witness 4 to be credible and consistent with her witness statement. In her oral evidence, Witness 4 stated that you were *"forcefully feeding"* the patient and that if that was her relative, she *"would not want someone to feed*

a relative or patient like that", that the patient *"spat food out"* and *"put his hand up"* to stop more spoonfuls coming. In her witness statement, Witness 4 stated:

> *"I saw [you] forcefully feed the patient their meal. The patient was chewing food that was in their mouth, however [you] had tried to shove another large spoonful of chicken into the patient's mouth. The patient had no time to finish one mouthful of their food before, [you] was on to the next spoonful…"*

The local statement of Ms 2 corroborated Witness 4's evidence that you were rushing the patient to eat:

> *"The nurse present [you] appeared annoyed about the time the patient was taking to eat his lunch…The nurse then picked up a tablespoon and scooped up a large amount of chicken and forcibly fed it to the male patient. He then spat out the food as it was too much to be able to eat in my opinion."*

The panel noted that Witness 4 and Ms 2 reported their concerns to Nurse A on the day of the incident and provided their written witness statements within one or two weeks. The panel was satisfied that Witness 4 provided a clear and consistent account of the incident and that it stood out to her as it occurred during her first student placement.

The panel also had regard to your oral evidence. It noted that you said you knew the patient better than [PRIVATE] (Witness 4 and Ms 2) did, and therefore although the feeding may have appeared to be rushed, it was not.

The panel preferred the evidence of Witness 4 because it was clear, consistent and corroborated by the statement of Ms 2.

The panel determined that, on the balance of probabilities, it was more likely than not that on 21 November 2018, whilst being subject to an informal capability process, you rushed an unknown patient to eat.

Accordingly, the panel finds charge 2a proved.

Charge 6a)

"On 10 December 2018 in respect of Patient A:

a) Failed to inform the nurse in charge that you had paused their syringe driver."

This charge is found proved.

In reaching this decision, the panel took into account of all the documentary and witness evidence before it.

The panel was satisfied that there is sufficient information before it to evidence that this incident took place on 10 December 2018. Despite some documentary inconsistencies, it was more likely than not that it was this date on the basis of the Datix, the syringe driver check sheet and the witness evidence of Nurse A, Nurse C and you.

The panel first considered whether you had a duty to inform the nurse in charge that you had paused Patient A's syringe driver. The panel noted that you said you did have a duty to do this.

Regarding the duty to inform the nurse in charge, Nurse C stated in her evidence that:

"If the interruption of continuous medication supply to patient happened I had to inform the nurse in charge of this straightaway as this could be classed as a serious incident"

Nurse A, who investigated this incident, stated in her evidence that as you were *"…the one who found the pump was alarming. [You] should have gone to find another registered nurse and sorted out the issue. [You] paused the alarm and did not report it to anyone."*

The panel determined that you did have a duty to inform the nurse in charge, be that Nurse C (the nurse in charge of the syringe driver pump for Patient A) or Nurse D [PRIVATE], that you had paused the syringe driver.

The panel next considered whether you had paused Patient A's syringe driver.

The panel had regard to your local witness statement, dated 23 December 2018, where you stated:

> *"…while returning back to her chair, the syringe driver started to alarm…I stop the alarm before going to look for the nurse in charge…by the time I got the nurse in charge…she said they have been told and she had already attended to the patient".*

The panel also had regard to your witness statement dated 24 January 2024, where you stated:

> *"…I paused the alarm which will automatically stop the flow…"*

In your oral evidence, you also accepted that when you paused the alarm the flow of medication would automatically stop.

The panel was satisfied that you knew that by pausing or pressing the alarm, Patient A's syringe driver pump would be paused, and that you understood the consequences of this were that the medication flow would stop.

The panel then considered whether you had failed to inform the nurse in charge.

You stated in your witness statement that:

"This lady buzzed for help and I attended. All I did was to assist this patient to the toilet for only few minutes. The toilet was on suite[sic]. *On her return to the bed area, I noticed that the syringe driver was bleeping, I stopped the alarm and I straight away inform my colleague who has primary duty to look after this patient that I stopped the alarm, I looked for my colleague [Nurse C] and when I eventually found her, I said; could you look into the syringe driver and she responded yes that she was already aware and dealing with it. To be clear, I was not the nurse that attended to the physical care of this patient including bed making for this patient that morning. My contact with her was brief and I did not stay in the room either before or after she buzzed for help or fiddled with the syringe driver at all as alleged by [Nurse C]. I have no reason to do so.*

…Also [Nurse D] came over to the nursing station and asked me, and I also told her what happened that the patient buzzed for help, I assisted her to the toilet and the syringe driver bleep, I stop the alarm."

In your oral evidence, you also stated that you had informed Nurse C and Nurse D that the syringe driver pump was bleeping and that you had paused the alarm.

The panel also had regard to the audio recording of your conversation with Nurse A on 22 December 2018, which you provided. When Nurse A asked you if you had found Nurse C you did not give a clear response. On the audio recording, you also said that you spoke with Nurse D in the treatment room. However, in oral evidence, you told the panel that you had spoken with Nurse D at the nursing station. In oral evidence, you told the panel that it took you *"a minute or two"* to locate Nurse C. However, in the audio recording, your local statement and your witness statement dated 24 January 2024, you appeared to indicate that you spent time looking for Nurse C.

The panel also had regard to the evidence of Nurse C, including her local statement dated 22 December 2018:

“Prior to helping with lunches I went into room 6 to check the driver was still running to time (this was at 1200hrs). The pump was found to be beeping although I am unsure at what time and when I checked, it had medication still in syringe but the driver said ‘pump paused for too long’. S/N Y. Akut had appeared in the room at this time and was filling out or reading over paperwork. I asked the patient if she had touched her driver and she said no. I asked S/N Y. Akut the same and she also said no. I said that ‘someone must have touched it as it is on pause’ and asked both if they knew who had touched the device. Both remained silent. S/N Y.Akut was now facing away from the patient and towards the door, reading from a folder, I asked the patient if she knew who had touched her driver and she nodded her head towards S/N Y. Akut. I informed [Nurse D] [PRIVATE]*, explaining in the blue corridor what had appeared to have happened.”*

The panel also considered Nurse C’s witness statement to the NMC dated 10 July 2023 and her oral evidence and found all her accounts to be consistent.

The panel also had regard to Nurse D’s local statement, dated 22 December 2018:

“[Nurse C] came to me saying that she had found patient A’s sub cut pump bleeping and saying ‘paused for too long’. I went to the patients room with [Nurse C]. [Nurse C] asked the patient , who is a very lucid lady, if she had touched the pump. The patient replied that a nurse had been doing that. The patient indicated with a head movement that the nurse who had been touching the pump was SN Akut who was in the room at the time.”

The panel also had regard to Patient A’s notes and your entry at 16:05 on 10 December 2018, approximately four hours after the incident:

> *"Assisted Patient A to toilet at 11:55 in low mood complaining pump is bleeping to call nurse in charge who is checking the pump. I only stop the alarm and was looking for my colleague to attend to her."*

The panel preferred the evidence of Nurse C to your evidence as it found all Nurse C's accounts to be consistent and credible. Nurse C's evidence was also supported by the contemporaneous evidence of Nurse D in her signed local statement at the time. The panel found your evidence to be inconsistent and it did not find you credible. The panel was not satisfied that you had informed the nurse in charge that you had paused Patient A's syringe driver.

The panel determined that you did fail to inform the nurse in charge, either Nurse C (the nurse in charge of the syringe driver pump for Patient A) or Nurse D [PRIVATE], that you had paused Patient A's syringe driver.

Accordingly, the panel finds charge 6a proved.

Charge 6b)

> *"On 10 December 2018 in respect of Patient A:*
>
> *b) Incorrectly told Nurse C and Nurse D that you had not touched the Syringe Driver pump when you were asked."*

This charge is found proved.

In reaching this decision, the panel took into account all the documentary evidence, witness evidence and considered its reasons for finding charge 6a proved.

The panel had regard to your witness statement dated 24 January 2024, which stated:

> *"I did not at any time inform [Nurse C], [Nurse D] or [Nurse A] that I did not touch this syringe. I told them that the syringe driver was bleeping, and I stopped the alarm."*

In your oral evidence, you also told the panel that at no time did you inform Nurse C, Nurse A or Nurse D that you did not touch the syringe driver.

The panel had regard to Nurse C's local statement, dated 22 December 2018:

> *"I asked the patient if she had touched her driver and she said no. I asked S/N Y. Akut the same and she also said no. I said that 'someone must have touched it as it is on pause' and asked both if they knew who had touched the device. Both remained silent."*

The panel also considered Nurse C's NMC witness statement:

> *"…I asked the patient if she had touched the syringe pump driver and stopped it and the patient said that she had not. I asked nurse Akut if she had done this but she also denied stopping the pump…*
>
> *…The patient was a lovely lady, with no signs of confusion so I felt confident that I could take that lady's word for it when I asked her if she had touched the pump, deliberately or accidently. When staff nurse Akut was facing away from the patient and towards the door reading from a folder I quietly asked the patient if she knew who had stopped the syringe driver and the patient nodded her head towards staff nurse Akut…"*

Nurse C's oral evidence to the panel was consistent with her written accounts as set out above.

The panel had regard to the statement of Nurse D, dated 22 December 2018:

"The patient indicated with a head movement that the nurse who had been touching the pump was SN Akut who was in the room at the time. When we left the room I took SN Akut aside and asked her if she had touched the pump. She told me she had not…I felt I had to escalate this as the patient was saying one thing and the nurse another"

The panel also noted the Datix, where Nurse A recorded that *"…staff member who assisted patient denies touching pump but has documented she paused the alarm…No clear proof of what happened, all staff involved are up to date with T34 competencies. Staff member who is suspected of pausing the pump currently under informal capability…"*

The panel had sight of your annotations on Patient A's notes, dated 10 December 2018 at 16:05, that the *"pump is bleeping"* and *"I only stop the alarm"*, as well as your local witness statement, dated 23 December 2018.

The panel also listened to the audio recording of your conversation with Nurse A on 22 December 2018 and noted that you told Nurse A that the syringe driver pump was buzzing and you *"pressed yes".*

The panel considered that Nurse C and Nurse D provided clear and consistent accounts of what happened immediately after the discovery that there was an incident with Patient A's syringe driver pump. Although you recorded at a later stage in Patient A's notes that you had *"only stop the alarm",* and told Nurse A on the 22 December 2018 that you had *"pressed yes"* to stop the buzzing or bleeping, the panel was satisfied that you incorrectly told Nurse C and Nurse D that you had not touched the syringe driver pump when you were asked.

Accordingly, the panel finds charge 6b proved.

Charge 7

"Your actions at charge 6b were dishonest in that you knew that you had paused the pump."

This charge is found proved.

The panel has found that you were aware that pausing or pressing the alarm would pause the syringe driver pump. The panel noted that in your oral evidence you stated that you were experienced in the use of syringe drivers and were up to date with your training.

Given that the panel has found 6b proved, the panel is satisfied that you knew that you had paused the pump and incorrectly told Nurse C and Nurse D that you had not touched the syringe driver. The panel was satisfied that your actions would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel finds charge 7 proved.

Charge 8a)

"On 24 December 2018 having been told by Nurse A on 22 December 2018 that Nurse E would discuss the accountability workbook with you:

a) Refused to discuss the accountability workbook with Nurse E"

This charge is found proved.

In reaching this decision, the panel took into account of all the documentary and witness evidence before it.

The panel noted that you accepted that you were told by Nurse A, on 22 December 2018, that Nurse E would discuss the accountability workbook with you on 24 December 2018.

The panel also had regard to the audio recording between you and Nurse A, which confirmed this. It was therefore satisfied that the stem of this charge was proved.

The panel then went on to consider whether you *'refused'* to discuss the accountability workbook with Nurse E.

The panel heard evidence from you and had regard to your witness statement, which stated:

> "…*I did not discuss accountability workbook with [Nurse E] on the 24 December 2018 not because I refused but because there was no time to discuss it as it was raised towards the end of my shift on 24 December 2018."*

The panel also considered Nurse E's witness statement, dated 11 January 2023, and noted that she said:

> *"She point blank refused to discuss it when I tried to hand her a blank copy."*

The panel also considered the oral evidence of Nurse E, which was consistent with her witness statement and her report of the shift to Nurse A on the 24 December 2018. Nurse E reported that you said that you *"would not be doing it or looking at it"*, that you *"should not have refused to do the workbook"* and recalled that you had made *"absolutely zero"* progress in the workbook.

The panel considered that Nurse E was consistent across all of her accounts of the shift with you and the panel found her to be credible. Both you and Nurse E agreed that this conversation took place towards the end of your shift, however, the panel was satisfied that you did refuse to discuss the accountability workbook with Nurse E.

Accordingly, the panel finds charge 8a proved.

Charge 8b)

"On 24 December 2018 having been told by Nurse A on 22 December 2018 that Nurse E would discuss the accountability workbook with you:

b) Incorrectly told Nurse E that Nurse A had not told you the accountability workbook would be discussed."

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and witness evidence before it.

The panel had regard to Nurse A's oral evidence and witness statement, dated 6 September 2021, which stated:

"During the discussion on 22 December 2018 I advised [you] to go through the accountability booklet with [Nurse E] however [Nurse E] advised me that [you] had stated that I had not mentioned this."

The panel considered your oral evidence and your witness statement, which stated:

"I remembered having a discussion about accountability workbook with [Nurse A] on the 22 December 2018 that I will go through it with [Nurse E] on 24 December 2018.
[…]
I was working between 7am and 4pm. I did not at any time told [Nurse E] that I was not told by [Nurse A] about accountability workbook, what had happened was that we had been busy all day doing the medication rounds together and offer other care to the patients, that we were not able to get to discuss the accountability workbook as this was only raised close to the end of my shift. She was shocked

when I told her I will be going home at the end of my shift at 4pm, probably she expected me work till 7pm"

The panel also heard evidence from Nurse E. In her report to Nurse A on 24 December 2018, she stated:

> *"Tried to go through accountability workbook however she said you did not mention this to her so she tried to veer off the subject"*

The panel also considered Nurse E's witness statement, dated 11 January 2023, and noted that she said:

> *"Yosi stated that [Nurse A] had not mentioned to [sic] book to her therefore she would not be doing it or looking at it.*
> *[…]*
> *She point blank refused to discuss it when I tried to hand her a blank copy. She said she had one at home, that she was not doing it today, she had not been asked by [Nurse A] to do it, she would not be taking it home and she would not do it."*

In oral evidence Nurse E also stated that you appeared to be *"surprised"* that the accountability workbook was going to be discussed.

The panel had regard to Nurse A's exhibit titled 'Yosi Timeline', in which Nurse A stated:

> *"I find this exceptionally disappointing as I had discussed the accountability booklet with Yosi on Saturday, explaining that she would be given time on Monday afternoon to go through this with [Nurse E]. She had looked through the booklet and I explained that I could not allow her to take it home as it was the only one I had and that I wanted her to complete it with [Nurse E]'s support. To read that she said I had not mentioned it to her is very disheartening considering she had the booklet in her hands and that we spent a good 5 minutes discussing it."*

The panel preferred Nurse E's evidence to yours. It found her evidence to be clear and consistent across all of her accounts and determined her evidence was credible and reliable in relation to what you told her.

Accordingly, the panel finds charge 8b proved.

Charge 9

> *"Your actions at charge 8b above were dishonest in that you knew Nurse A had told you that Nurse E would be discussing the accountability workbook with you."*

This charge is found proved.

The panel then went on to consider whether your actions in charge 8b were dishonest, and in doing so, it had regard to the same evidence as above.

The panel considered the evidence and noted that you acknowledge that you *"remembered having a discussion with Nurse A"* that you were to *"go through"* the accountability workbook with Nurse E. The panel also noted that it was clear in the audio recording that Nurse A told you that you would be discussing the accountability workbook with Nurse E on 24 December 2018.

The panel has found that you incorrectly told Nurse E that Nurse A had not told you the accountability workbook would be discussed and it determined that you must have known you had done that.

The panel determined that your actions in incorrectly stating that Nurse A had not informed you to discuss the accountability workbook would be regarded as dishonest by the standards of ordinary decent people.

Accordingly, the panel finds charge 9 proved.

Charge 14c)

"On 26 April 2019 you:

c) Shouted at Nurse A that she "would be struck down by god" or words to that effect."

This charge is found proved.

In reaching this decision, the panel took into account all the documentary and witness evidence before it.

The panel heard oral evidence from Nurse A, which was consistent with her written statement dated 6 September 2021. It noted that there was no contemporaneous documentary evidence of this incident. The panel considered that in her oral evidence Nurse A gave a very clear and detailed account of the incident on 26 April 2019. Further, in response to a direct question from the panel, Nurse A acknowledged that she *"didn't write it down"* and could not remember why. Nurse A went on to state that she was exhausted by this stage as you were consistently shouting at her and your behaviour was aggressive and bullying. However, Nurse A was very clear in her recollection and stated that you *"definitely said it".*

The panel also heard oral evidence from you and had regard to your witness statement:

"I am a Christian. I do not believe in god with small 'g' and I cannot place anyone under a curse of the big God as I am only a mere mortal and a mere dust. I only know how to pray, and I cannot curse under any circumstances, and I did not curse [Nurse A]. She must have misconstrued this one. Nonetheless, I am very sorry if that is how she felt."

The panel noted that you accept charges 14a and 14b that, on 26 April 2019, you acted in an aggressive manner towards Nurse A and shouted and/or screamed at Nurse A.
The panel found Nurse A's detailed description of events on 26 April 2019 to be credible. The panel determined that, on the balance of probabilities, it was more likely than not that you shouted at Nurse A and used words to the effect that she *"would be struck down by god*".

Accordingly, the panel finds charge 14c proved.

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

During his submissions on misconduct and impairment, Mr Oyegoke made a request that the hearing be held partly in private on the basis that proper exploration of your case involves reference to [PRIVATE]. He referred the panel to documents provided by you which contain information relating to [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

Ms Danti did not oppose the application.

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 noted that this application was not opposed. The panel determined that it was justified to go into private session as and when matters relating to [PRIVATE] are raised or referred to, in order to protect your privacy in these proceedings.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to a lack of competence (in respect of charges 1, 2 and 3) or misconduct (in respect of charges 4, 5, 6, 7, 8, 9, 11, 14, 15 and 16) 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 ability to practise kindly, safely and professionally.

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 lack of competence and/or misconduct. Secondly, only if the facts found proved amount to misconduct and/or lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct and/or lack of competence.

Prior to hearing the submissions in relation to this next stage, the panel heard live evidence from a witness called on your behalf. Witness 5, the Home Manager at Cooper House Care Home (the Home) where you have worked and volunteered from 20 March 2023 to date, gave evidence under affirmation.

Submissions on lack of competence and misconduct

In relation to lack of competence, Ms Danti referred the panel to the relevant NMC guidance (FTP-2b) and stated that this set out that:

> *"a 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 of harm. For instance, when a nurse also demonstrates a lack of*

knowledge, skill or judgment, showing their incapable of safe and effective practice."

Ms Danti invited the panel to consider the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) as a whole in making its decision. However, she also drew the panel's attention to specific relevant standards and she submitted that your actions demonstrated a lack of competence. Ms Danti 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?

Ms Danti submitted that the panel can answer '*yes'* to all three questions on the basis of the live witness testimonies, documentary evidence and audio recording before it. She submitted that in particular the oral evidence from Nurse A and Nurse E demonstrate that you were made aware of the concerns around your competence and received support at work to improve. Further assessments were undertaken however you did not cooperate and repeatedly made errors over a long period between September 2018 and October 2019.

Ms Danti referred to specific examples from the facts found proved where she submitted that your errors caused harm to patients or put them at risk of harm. She submitted that your actions fell seriously short of the conduct expected of a registered nurse in your position. Ms Danti invited the panel to find that your competence at the time was below the standard expected of a Band 5 registered nurse.

In relation to misconduct, Ms Danti referred the panel to the case of *Roylance v General Medical Council (GMC) (No. 2)* [2000] 1 AC 311, which defines misconduct as a *'word of*

general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

Ms Danti submitted that the standard of '*what would be proper in the circumstances'* can be found by reference to the standards ordinarily required to be followed by a registered nurse. She submitted that you, as a registered nurse, are required to abide by the standards of the Code. Ms Danti invited the panel to have regard to the entirety of the Code but highlighted specific relevant standards where she submitted that your actions fell below the standards required and amounted to misconduct.

Ms Danti invited the panel to take the view that the facts found proved amount to misconduct. She submitted that your actions, such as shouting at patients and colleagues, failing to administer medication when required, refusing to complete a learning activity to ensure safe practice and being dishonest, reflects a serious falling short of the professional standards. She highlighted the vulnerability of the patients involved and the actual or potential harm and distress caused. Ms Danti also emphasised the seriousness of dishonesty and its impact, particularly on public confidence in the profession.

In response, Mr Oyegoke submitted that a breach of the Code does not automatically amount to a lack of competence or misconduct. In relation to misconduct, he submitted that the panel must assess seriousness and whether the conduct would be considered '*deplorable*' before it can find that a breach of the Code amounts to misconduct. He referred to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin).

Mr Oyegoke submitted that you made admissions at the outset of the hearing to some of the charges, but he submitted that you did not accept that your actions amount to misconduct. He emphasised that the panel should still consider seriousness for each of the facts found proved and not automatically find misconduct in light of any admission. He also asked the panel to bear in mind that there is no burden on you to prove anything. Mr Oyegoke submitted that the panel should consider exercising their judgement on a

professional standard, which was a little lower than the civil standard, and more like an objective test.

In assessing a lack of competence, Mr Oyegoke submitted that the panel should have regard to the context of your overall activities and professional history. He submitted that any issues the panel may find in relation to competence, can be easily remediated.

Mr Oyegoke further submitted that some of the charges, in particular, charge 15, which the NMC considered to amount to misconduct, are still part of a competency issue, which can easily be remediated. He submitted that not all the charges found proved are of the same grade of seriousness and not all breaches of the Code constitute misconduct.

Submissions on impairment

Ms Danti moved on to the issue of impairment, she outlined that if lack of competence or misconduct is found, the panel must assess whether your fitness to practise is currently impaired. She 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. With reference to the cases of *Council for Healthcare Regulatory Excellence (CHRE) v (1) NMC (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

Ms Danti submitted that whilst some charges were admitted by you at the outset of the hearing, you lack insight into your actions and the impact of these on patients, colleagues, and the public. She referred to specific examples in your reflections and she submitted that you appeared to attempt to avoid, or shift blame onto others or minimise the harm caused by your lack of competence. In respect of your misconduct and dishonesty, Ms Danti highlighted the inconsistencies in your reflection, particularly that you '*apologise*' if you '*gave the impression of being dishonest'*. Ms Danti submitted that there is lack of insight into your dishonest conduct as your evidence was contradictory.

Ms Danti acknowledged the several training certificates you provided to demonstrate remediation. However, she submitted that these efforts do not sufficiently address the underlying attitude and conduct concerns, especially regarding shouting at a patient and colleagues or dishonesty. In relation to dishonesty, Ms Danti submitted arguably the dishonesty in this case is not capable of remediation. She submitted that dishonesty was not addressed in your professional development plan and that you only completed a duty of candour course in January 2024 which amounted to half an hour of Continuous Professional Development (CPD).

Ms Danti also submitted that whilst you have completed more than 10 shifts at the Home, the dates suggest some gaps in shifts.

Ms Danti submitted that there is a risk of harm to patients if such instances of misconduct and lack of competence are repeated, particularly as you show a lack of acceptance of responsibility and are yet to address underlying attitudinal issues. Therefore, she submitted that a finding of current impairment is necessary on the ground of public protection.

Ms Danti also invited the panel to take the view that a finding of current impairment is also necessary on public interest grounds to uphold standards and maintain confidence in the nursing profession and mark the seriousness of both your misconduct and lack of competence.

In response, Mr Oyegoke invited the panel to bear in mind that the question of current impairment is a forward-looking exercise. He submitted that the panel should consider the documentary and witness evidence before it to discern whether your fitness to practise is impaired at present. He submitted that if the panel wish to mark the seriousness of any conduct, this can be done through a finding of misconduct or lack of competence. Your attendance and engagement in the rigorous proceedings was sufficient and it would not be necessary for the panel to make a finding of impairment. He further submitted that this

would send a signal to the public and the nursing profession that such behaviours cannot be accepted.

With reference to the case of *Cohen*, Mr Oyegoke submitted that a finding of misconduct/lack of competence does not automatically lead to impairment. Similarly, in relation to dishonesty, he referred the panel to the cases of *GMC v Uppal* [2015] EWHC 1304 (Admin) and *PSA v NMC* [2017] CSIH 29 and submitted that a finding of dishonesty does not automatically lead to a finding of impairment. He also submitted that Nurse A and Nurse E stated that they were not accusing you of dishonesty. Mr Oyegoke also referred to other relevant case law on good character. He submitted that the issue of good character is applicable at every stage, and he referred the panel to your documentary evidence including positive testimonials and the witness evidence from your current line manager.

Mr Oyegoke submitted that you have provided detailed and extensive multiple reflections in which you show your insight into your actions, your feelings, what you have learnt and your action plan of what you would do in the future. He opposed the submissions of Ms Danti and referred to further case law which set out that a rejected defence does not automatically lead to a finding of lack of insight. He invited the panel to consider your reflective pieces as a whole and see the progress in your insight from the time of the incidents to now. He submitted that you have reflected on your past actions and on how you will ensure these will not happen again.

Mr Oyegoke submitted that you have taken steps to strengthen your practice and that your current personal development plan (PDP) addresses the relevant areas of concern with your practice. He submitted that Witness 5, who is your line manager, is satisfied with your performance. He further submitted that you have worked at the Home for more than 40 shifts, that there are no issues with your current practice and the Home is happy to have you back consistently. He also referred to the training you have undertaken covering the relevant areas which were identified as requiring improvement.

Mr Oyegoke submitted that the panel should consider [PRIVATE] at the time which had an impact on your work [PRIVATE]. He referred to the [PRIVATE] evidence in your bundle. Mr Oyegoke submitted that there is no risk of repetition in the future. He highlighted that there are no previous nor subsequent incidents, there is evidence that you have learnt from this and that your current workplace is happy with your performance. Therefore, a finding of impairment is not necessary on either public protection or public interest grounds.

The panel accepted the advice of the legal assessor which included reference to NMC guidance and a number of relevant judgments. These included: *Roylance v GMC* (No 2) [2000] 1 A.C. 311, *Nandi v GMC* [2004] EWHC 2317 (Admin), *Giele v GMC* [2005] EWHC 2143 (Admin), *GMC v Meadow* [2007] QB 462 (Admin), *Ronald Jack Cohen v GMC* [2008] EWHC 581 (Admin), *Cheatle v GMC* [2009] EWHC 645 (Admin), *CHRE v Grant* [2011] EWHC 927 (Admin), *GMC v Uppal* [2015] EWHC 1304 (Admin), *GMC v Armstrong* [2021] EWHC 1658 (Admin), *Ahmedsowida v GMC* [2021] EWHC 3466 (Admin), and *Dr Sawati v GMC* [2022] EWHC 283 (Admin).

In response to Mr Oyegoke's submissions, the legal assessor clarified that it was not open to the panel to make alternative findings of lack of competency on charges brought by the NMC under misconduct. The legal assessor also clarified that in reaching its decisions, there is no burden or standard of proof to be applied by the panel. The decisions of misconduct, lack of competence and impairment remain matters within the judgement of the panel.

Decision and reasons on lack of competence

When determining whether the facts found proved and/or admissions 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***

To achieve this, you must:

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

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.4 take account of your own personal safety as well as the safety of people in your care

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

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

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.”*

The panel bore in mind, when reaching its decision, that you should be judged by the standards of a reasonably competent Band 5 registered nurse and not by any higher or more demanding standard.

In considering the matter of lack of competence, the panel considered each of the charges found proved individually first, and then collectively.

Charge 1

The panel considered the witness evidence of Nurse A, who stated that: *“Yosi never wanted to work with anyone, even those patients who required two staff members she would do alone as she did not want to work with anyone else”.* The panel considered the context of the Ward at the time, it noted from the oral evidence of Nurse A that most patients were *“very physically dependent”* and *“should be nursed by at least two members of staff”* as trying to do so alone *“would cause a risk to the patient…pull them and hurt them…and the staff member would also be putting themselves at risk by trying to manoeuvre somebody that's not able to lift their leg…or assist in any way”.*

The panel determined that a Band 5 registered nurse in your position would be expected to understand the importance of ensuring that two members of staff were present to provide care to patients that required two members of staff.

The panel concluded that your actions, in providing care on your own to patients that required two members of staff, demonstrated poor judgement and breached the standards set out in the Code. In particular, the panel identified sections 1.1, 1.2, 8, 8.2, 8.5, 13.4 and 19.1 as relevant. The panel determined that you did not prioritise patient safety, nor your own safety, by providing care to patients on your own when they required two

members of staff to assist. The panel was satisfied that this was a serious falling short and you did not demonstrate the knowledge, skill and judgement expected of you. The panel determined that your actions fell far below the standards required of a registered nurse and amounted to a lack of competence.

Charge 2a

The panel determined that in rushing a patient to eat, you did not treat the patient with respect and dignity and failed to prioritise the patient's safety and needs. The panel determined that your actions placed the patient at unwarranted risk of harm. The panel also noted the impact on the two student nurses who witnessed this incident. The panel determined that you failed to act as a role model of professional behaviour for the student nurses to aspire to.

The panel found that you breached the standards set out in the Code, specifically sections 1.1, 1.2, 2.6, 20.5 and 20.8. It was satisfied that your behaviour was a serious falling short of the standards expected of you and you did not demonstrate the knowledge, skill and judgement expected of you. Therefore, the panel determined that your actions fell significantly below the standards required of a registered nurse and amounted to a lack of competence.

Charge 2c

The panel had regard to Nurse A's evidence:

> *"Another concern was raised, a patient had had a fall during a previous shift [1 December 2018]…medical staff reviewed the patient and in their notes the doctors said if swelling appears and range of movement decreases an X-ray of the patients elbow would be required.*

On 2 December 2019 when Yosi came on shift she assisted the patient with their personal hygiene and did not mention anything about the elbow. When a support worker went into [sic] to see the patient they noted the elbow was very swollen and the patient was in pain so the out of hours doctor was called and an X-ray was arranged. From the notes Yosi had supposedly been in an completed a full skin inspection on this patient."

The panel considered that in failing to carry out the necessary skin inspection and failing to identify/document a swollen elbow following a fall, you fell below the standards required of you. The panel was satisfied that you failed to fulfil your duties to care for the patient.

The panel found that you breached the standards set out in the Code, specifically sections 1.1, 1.2, 1.4, 10.2 and 13.1. It was satisfied that your behaviour was a serious falling short of the standards expected of you and you did not demonstrate the knowledge, skill and judgement expected of you. Therefore, the panel determined that your actions fell far below the standards required of a registered nurse and amounted to a lack of competence.

Charge 2d

The panel considered that communication with patients for safe and effective practice is a fundamental nursing skill. It noted that this incident concerned a vulnerable patient with dementia, so it was even more important to maintain clear communication when moving them following a fall.

The panel considered your actions breached the standards set out in the Code, specifically sections 1.1, 1.2, 2.6, 7.3, 19.1 and 20.5. It concluded that you did not demonstrate the knowledge, judgement and skill expected of you. Therefore, the panel determined that your actions fell far below the standards required of a registered nurse and amounted to a lack of competence.

Charge 2f

The panel determined that in rushing and/or being rough with an end-of-life patient when assisting her to the toilet, your actions did not demonstrate kind, safe and professional practice. The panel considered your actions breached the standards set out in the Code, specifically sections 1.1, 1.2, 1.5, 2.6, 3.2 and 20.5. It concluded that you did not demonstrate the knowledge, skill and judgement expected of you. Therefore, the panel determined that your actions fell significantly below the standards required of a registered nurse and amounted to a lack of competence.

Charge 2g

The panel considered that communication with patients for safe and effective practice is a fundamental nursing skill. The panel considered that careful communication is a key part of administering an injection to a patient with dementia as this would ensure that the procedure is done safely and with the least possible distress to the patient.

In failing to communicate clearly with the patient, you did not demonstrate kind, safe and professional practice and your actions breached the standards set out in the Code, specifically sections 1.1, 1.2, 2.6, 7.3 and 20.5.

The panel determined that you did not demonstrate the knowledge, skill and judgement expected of you. Therefore, the panel determined that this was a serious falling short of the standards expected of a registered nurse and amounted to a lack of competence.

Charge 2h

The panel noted that a nurse of your experience should be familiar with and be able to use the controls of a hospital bed. However, it found that the evidence in relation to this charge suggests that this was a simple mistake or misunderstanding about what you were asked to do with the bed. The panel noted that there was no evidence that this error happened

on more than one occasion. The panel therefore found that this failure did not fall significantly below the standards in the specific circumstances, and it was not satisfied that this specific failing amounted a lack of competence.

Charge 2i

The panel determined that in using an out-of-date manual handling technique, your actions did not demonstrate safe and effective practice, and the patient was put at risk of harm. Further, failing your manual handling training in April 2019 showed that you did not have the knowledge and skill required of a registered nurse. The panel determined that you should have kept up to date with fundamental nursing practice. The panel considered your actions breached the standards set out in the Code, specifically sections 1.2 and 6.2. and determined that this was a serious falling short of the standards expected of a registered nurse and amounted to a lack of competence.

Charge 2j

The panel accepted the evidence of Nurse A that the appropriate course of action was for you to wait until the patient's death was verified before removing the urinary catheter. The panel considered your actions breached section 1.2 of the Code. It concluded that you did not demonstrate the knowledge, skill and judgement expected of you as you should have known that verification of death must take place first following the death of a patient and the importance of this. Therefore, the panel determined that your actions fell seriously short of the standards expected of a registered nurse and amounted to a lack of competence.

Charge 2k

The panel had regard to the witness statement of Mr 4. It considered that your action in leaving a patient alone in the toilet was not safe and effective practice. The panel noted

that this incident concerned a vulnerable patient who was at high risk of falls, so it was even more important to ensure that you were close by to assist them.

The panel considered that your actions breached the standards set out in the Code, specifically sections 1.1, 1.2 and 19.1. It concluded that your actions put the patient at risk of harm as they could have fallen or injured themselves. The panel determined that you did not demonstrate the knowledge, skill and judgement expected of you, and therefore, your actions fell significantly below the standards expected of a registered nurse and amounted to a lack of competence.

Charge 2l

The panel considered that being able to use a falls monitor is a fundamental nursing skill. The panel noted that a falls monitor is essential equipment frequently used by a nurse in your role, working with vulnerable elderly patients. It noted that you could have also asked colleagues for help in operating the falls monitor if you were unfamiliar with it.

The panel found that by not ensuring you were familiar with key equipment designed to keep patients safe, you put patients at risk of significant harm, and therefore, you did not maintain safe and effective practice.

The panel determined that you breached the standards set out in the Code, specifically sections 1.2, 6.2 and 19.1 and you did not demonstrate the knowledge and skill expected of you. The panel determined that your actions were a significant falling short of the standards expected of a registered nurse and amounted to a lack of competence.

Charge 3a

The panel had regard to each of the subsections of this charge individually at first, and then collectively. The panel considered that, in not being able to explain what you should do in an emergency scenario where a cord was wrapped around a patient’s neck, you did

not have the knowledge expected of you. The panel considered that you could have put patients at risk of harm as you would be unable to respond appropriately in such emergency circumstances.

The panel determined that this was a breach of the standards set out in the Code, specifically section 6.2. The panel concluded that you did not demonstrate that you were capable of safe and effective practice and therefore, fell significantly below the standards expected of you. The panel determined that your actions were a significant falling short of the standards expected of a registered nurse and amounted to a lack of competence.

Charges 3b to 3e

The panel had regard to each of these charges individually at first, and then collectively. It noted that these charges refer to similar failures in relation to the risk assessments for the same patient on the same day, 17 October 2019.

The panel has taken into account all the information provided, the context and timeline in which the circumstances arose, as well as the notes of your handover to the night team. The panel acknowledged that this specific shift was very busy, and both your evidence and the witness evidence supported this. The panel had particular regard to the evidence of Nurse B, who confirmed that you completed a handover of the patient to the nurse on the following shift.

The panel noted the importance of carrying out the necessary risk assessments as soon as possible following the admission of a patient and noted your failure to complete these as required. However, whilst the panel found that your actions fell below the standard required of you, it was not satisfied that your actions amounted to a lack of competence, when considering the specific circumstances in which these charges arose.

Charge 3f

For the reasons set out in charges 3b to 3e above, the panel also determined that your failure to complete risk assessments for unknown patients within a 24-hour time frame fell short of the standards required of you but did not amount to a lack of competence.

Lack of competence conclusion

The panel was satisfied that there was evidence that you were made aware of the issues around your competence, you were given an opportunity to improve, and your competence was further assessed. The panel noted that you were subject to an informal capability process from 2018 and thereafter subject to an informal capability action plan. The panel heard evidence from various witnesses who were involved in supporting you through your capability process and assessing your competence.

Overall, the panel concluded that your actions, both individually and collectively, formed a pattern of failures in fundamental nursing practice over a significant period of time including in particular, failures in communication, failures in patient safety and care, lack of knowledge, skill and poor judgement. It noted that the evidence before it provided a sample of your work between September 2018 and August 2020. The panel determined that your practice fell far below the standards expected of a registered Band 5 nurse of your experience. In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on misconduct

When determining whether the facts found proved and admitted amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code. Specifically:

*‘**1** **Treat people as individuals and uphold their dignity***

To achieve this, you must:

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 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.6 recognise when people are anxious or in distress and respond compassionately and politely

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work cooperatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues…

8.2 maintain effective communication with colleagues

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

8.5 work with colleagues to preserve the safety of those receiving care

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

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

22 Fulfil all registration requirements

To achieve this, you must:

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In reaching its decision, the panel considered each of the following charges individually at first, and then collectively.

Charge 4

The panel determined that not completing an accountability workbook, when requested to do so by Nurse A, was serious as this was arranged in order to assist you to address the concerns relating to your practice. Given that you were subject to an Informal Capability Action Plan, it was of greater importance that you completed this in order to ensure that you could practise safely and demonstrate professional accountability. The panel also found that your actions could have put patients at risk of harm as you delayed your progress in addressing the concerns in relation to your practice.

Further, the panel noted that the period between 1 September 2018 and 29 July 2019 was a sufficient period of time for you to complete the workbook. By not completing it in the time period specified, you failed to follow instructions from your manager. The panel was of the view that your failure to complete the workbook indicated underlying attitudinal issues. The panel determined that you breached the standards of the Code, specifically

sections 6.2 and 22.3. The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 5

The panel determined that your actions in shouting at a patient on more than one occasion was a significant departure from the standards set out in the Code, specifically sections 1.1, 20.1, 20.3, 20.5 and 20.8. The panel determined that it is not acceptable to shout at a patient. It also considered that such conduct could put patients at risk of harm, particularly emotional harm, as these were vulnerable elderly patients. The panel found that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charges 6 and 7

The panel had regard to each of the charges individually at first, and then collectively, as these were interlinked given that they related to the same incident. The panel determined that your actions in failing to inform the nurse in charge that you paused the syringe driver were very serious. The panel found that you put Patient A at risk of harm as their medication was stopped due to the pause of the syringe driver and a delay could have significantly impacted their health. The panel considered that, as an experienced nurse, you should have known the importance of communication to address any issues swiftly, in order to resume the patient's medication flow. The panel noted that you breached the duty of candour expected of nurses by being dishonest rather than taking responsibility for your actions.

The panel determined that your actions amounted to a significant departure from the standards set out in the Code, specifically sections 1.1, 1.2, 1.4, 2.1, 8.2, 8.5, 8.5, 14.1, 14.2, 14.3, 19.1, 20.1, 20.2, 20.3, 20.5 and 20.8. The panel found that your actions fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charges 8 and 9

The panel had regard to each of the charges individually at first, and then collectively, as these were interlinked given that they related to the same incident. The panel determined that refusing to discuss the accountability workbook with Nurse E was serious as it showed a disregard for the importance of the workbook as a method of assisting you in reaching the standards required of you.

Further, being dishonest with Nurse E regarding Nurse A's instructions was a breach of your duty of candour and unacceptable behaviour, as nurses are expected to act with honesty and integrity.

The panel concluded that your conduct was a significant departure from the standards set out in the Code, specifically sections 6.2, 8.2, 8.4, 20.1, 20.2 and 20.3. The panel determined that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charges 11a, 11b and 11c

The panel had regard to the evidence of Nurse A:

> *"…She was unwilling to listen to me, shouting…consistently telling me in a raised voice that I had not given her support…At this point I asked her to leave the office…she refused to leave the office…*
>
> *…This episode lasted for a good couple minutes before she eventually left the office. I found her behaviour to be unprofessional, aggressive and very inappropriate. Her behaviour towards me made me feel extremely uncomfortable and I was eager for her to leave the office as she was making a scene and I was*

> *very aware that both patients and relatives would have been able to hear her shouting at me and making accusations…"*

The panel determined that shouting at Nurse A and acting in an aggressive manner towards Nurse A, were unacceptable and a significant departure from the standards set out in the Code, specifically sections 8.1, 9.3, 20.1, 20.3, 20.5 and 20.8.

The panel considered that your refusal to leave when requested to do so by Nurse A was intimidatory behaviour and caused Nurse A distress. The panel noted your behaviour took place in an area where patients and their relatives could hear and would have negatively impacted patients' and the public's confidence in the nursing profession. The panel determined that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charges 14a, 14b and 14c

The panel noted that Nurse A particularly remembered this incident and in oral evidence she stated that your behaviour was *"out of control"*. The panel considered that the words *"struck down"* were threatening and intimidatory. The panel noted that charges 11 and 14 were similar in that both concern your aggressive behaviour towards Nurse A. The panel determined that your repeated aggressive behaviour towards Nurse A was unprofessional, unacceptable and a significant departure from the standards set out in the Code, specifically sections 8.1, 9.3, 20.1, 20.3, 20.5 and 20.8. The panel determined that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charge 15

The panel had regard to the evidence of Nurse B and Ms 6. In Ms 6's witness statement, she stated that:

‘…This ward was occupied by the patients who have multiple serious conditions and required complex care including end of life care…

…Patient B needed to be administered oral morphine (oramorph) as a PRN medication when she asked for it. Oramorph was prescribed to for shortness of breath…

…Patient B told me that when she had asked Yosi for oramorph an hour earlier, Yosi told her that I was on my break. Yosi did not give oramorph to Patient B when she asked for it.

I was not aware that had asked for oramorph and it was Yosi’s responsibility to inform me of that. Also, Yosi should have given PRN oramorph to as soon as she asked for it rather than waiting for me to do this…

…As a result of the above incident there was about an hour delay in administration of PRN oramorph to the patient. I don’t remember if Patient B had shortness of breath when she spoke to me.

To my knowledge has not suffered harm as a result of the delayed administration of PRN oramorph. However she would have been in distress while waiting for the medication.’

The panel noted that Patient B was an end-of-life patient and required Oramorph for their shortness of breath and your failure to administer Patient B’s Oramorph when requested was serious as it would have caused Patient B distress. The panel also noted that PRN medication should be provided to a patient as and when required, so a delay in doing so is not prioritising a patient’s needs. The panel considered that you should have given Oramorph to Patient B at the time of her request, or you should have communicated with another colleague, as opposed to ignoring Patient B’s request.

The panel determined that your actions were a significant departure from the standards set out in the Code, specifically sections 1.1, 1.2, 1.4, 2.6, 20.1 and 20.5. The panel determined that you failed to practise kindly, safely and professionally and your actions fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charge 16

The panel noted that charge 16 is of similar nature to charges 11 and 14 as it concerns your aggressive conduct towards colleagues and shouting at Nurse B in this instance. The panel determined that your repeated aggressive behaviour towards colleagues was unprofessional, unacceptable and a significant departure from the standards set out in the Code, specifically sections 8.1, 9.3, 20.1, 20.3, 20.5 and 20.8. The panel determined that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Misconduct conclusion

In all the circumstances, the panel found that your actions, individually and collectively, fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. 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.

The panel had regard to the NMC Guidance on Impairment (DMA-1) and considered whether you as a registered nurse could practise kindly, safely and professionally.

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; and/or

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel was satisfied that all four limbs of *Grant*, as set out above, were engaged.

The panel determined that patients were put at unwarranted risk of harm as a result of your lack of competence. For instance, in rushing or being rough with patients when you were assisting them in eating or going to the toilet; in providing care alone when two members of staff were required for safety; in your use of an outdated moving and handling technique on a patient and in leaving a patient unattended when they were at high risk of falls. You have breached the fundamental tenets of the nursing profession, which include prioritising people, practising effectively, preserving safety and promoting professionalism and trust, and you have also brought the reputation of the nursing profession into disrepute.

In relation to misconduct, the panel determined that patients were put at risk of harm as a result of your actions. Your misconduct breached fundamental tenets of the profession and brought the nursing profession into disrepute as you behaved in an aggressive manner towards colleagues, shouted at a patient and colleagues, failed to cooperate with colleagues and failed to ensure that a patient received medication in a timely manner. Your misconduct included breaches of your duty of candour and the panel determined that you acted dishonestly.

In all the circumstances, the panel determined that your fitness to practise was impaired in the past.

The panel carried out a forward-looking exercise and assessed whether your lack of competence and misconduct are remediable. Whilst the panel noted that dishonesty is

always difficult to remediate, it considered that the lack of competence and misconduct identified in this case could be capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not you have strengthened your practice sufficiently and whether or not you are currently impaired.

The panel recognised that although you did not express remorse at the time of the incidents, you expressed extensive remorse for your actions in your detailed reflective piece dated April 2024. You stated:

> *'If given the opportunity, I would like to apologise to all my patients who were affected by these allegations. I would also like to apologise to my colleagues who are directly affected in all the events and scenarios that I mentioned in my reflections, those that I have wrongly labelled as racist, I am sorry, after all, I had harmoniously worked with these groups for more than 18 years previously before I was put on capability action plan following [PRIVATE]. They all sought safety of patients. To my wider colleagues who are working very hard to sustain and maintain the trust and confidence the public has in nurses for bringing the nursing profession into disrepute.*
>
> *I also like to apologise to my employer for the breakdown of trust and confidence. I wish to apologise to the members of the public for conducting myself below their expectation of how a nurse should perform. Lastly, I apologise to the Nursing and Midwifery Council the regulator of nurses for bringing the nursing profession into disrepute.'*

The panel also recognised that you made admissions to a number of the charges at the outset of the hearing.

The panel went on to consider whether you have sufficient insight into your misconduct and lack of competence. The panel had regard to all your evidence including your detailed reflective piece and the oral evidence you gave to the panel. The panel recognised that

you demonstrated some understanding of why what you did was wrong and why you had failed to meet the standards expected of you. In your reflective piece dated April 2024, you explored, to some extent, how you would handle similar situations in the future.

However, the panel found contradictions within your reflections. The panel determined that for some incidents, you minimised the impact of your behaviour, attempted to shift blame and failed to demonstrate that you were accountable for your behaviour. These included:

- In relation to the manual handling incident where you used an out-of-date technique, you stated in your reflective piece that you did not receive feedback from your manual handling assessment. However, the panel had documentary evidence before it that feedback was provided to you by the person who conducted the competency assessment on 12 April 2019.

- In relation to leaving a patient alone who was at a high risk of falls, your explanation for doing this was that you must have had an urgent call to attend to. In your reflection, you do not appear to recognise the gravity of your error and the fact that you placed the patient at potential risk of harm. You stated, '*it would have been disclosed if there was any outcome worthy of mention'*. The panel was not satisfied that you fully accepted responsibility for your behaviour.

- In relation to charge 2c, your failure to carry out a skin inspection and failure to identify and/or document that a patient's elbow was swollen, the panel determined that you minimised the impact of your behaviour on the patient. In your reflection, you stated that '*the outcome for this patient was however positive because the X-ray revealed no fracture or injury to soft tissue'*. The panel determined that you did not take full responsibility for your behaviour.

- In relation to charge 2a where you rushed an unknown patient to eat, the panel determined that you minimised the impact of your behaviour, failed to take responsibility and be accountable and sought to shift blame. Your reflection focused

on the lack of communication between you and the two [PRIVATE] nurses and the timing of your line manager raising the incident with you. You failed to appreciate the impact on the patient and the potential harm of your behaviour. You stated that '*what was good was that the patient did not choke or vomit either during or after the meal'*.

- In relation to charge 2j, where you had to be prompted not to remove a urinary catheter until death was verified, you stated that this incident was a '*near miss as I did not actually remove the urinary catheter after being prompted'*. The panel considered that you failed to take responsibility and be accountable for your behaviour and sought to minimise the impact of it.

In relation to your reflections on your dishonesty, the panel noted that some of the language you used in exploring this was conflicting. For example, in relation to the accountability workbook, you stated in your written reflection:

> *'It was not good that I did not complete the accountability workbook with (*Nurse E*) on the first day we worked together. It was equally bad that I insisted to her that I was not told to complete accountability workbook with her and that I will not complete it with her. That is dishonest which is against the fundamental tenet of the nursing profession.'*

In your conclusion, you contradicted yourself and stated:

> *'I like to apologise to* (Nurse A) *and* (Nurse E) *if I gave her the impression that I was dishonest about the accountability workbook as that was not my intention, but I was rather genuinely eager to get the workbook completed.'*

In relation to the syringe driver incident, you stated in your reflection:

'It is essential for nurses to be honest in all their dealings for the safety and protection of the patient. It was regrettable that I was dishonest in this instance regarding denying touching the syringe driver when in actual fact that I have paused the alarm. Dishonesty is against the fundamental tenet of the nursing profession; a dishonest nurse may commit an error in the care of the patient and conceal it leading to serious complication or even fatal consequence.'

In your conclusion, you stated:

'For my colleagues involved in the syringe driver incident, I say sorry for the misunderstanding this might have caused between us.'

The panel was not satisfied that you had fully acknowledged or accepted your dishonest behaviour. It considered that your conclusions in your reflection focused on what you believed were *'impressions'* of dishonesty and '*misunderstandings*'. The panel determined that whilst you apologised for your behaviour, your reflections lacked clarity and detail as to what motivated your actions at the time.

The panel also noted that in January 2024, you completed e-learning on the duty of candour which qualified for a minimum of 0.50 CPD hours/points. It also had regard to the evidence of Witness 5 and your professional development plan and noted that you had not been signed off as competent by the Home, in the duty of candour. The panel noted that you are working towards completing this. The panel concluded that your remediation into your dishonesty is insufficient and incomplete.

Therefore, the panel was not satisfied that you demonstrated sufficient insight into your dishonesty, your lack of competence and misconduct.

The panel carefully reviewed the relevant training you have undertaken including numerous certificates for online training in courses such as: falls prevention, equality and diversity, control and administration of medicines (level 3), eating, drinking and food

hygiene, moving and handling of people, safeguarding of vulnerable adults, care planning and risk assessment and conflict resolution. The panel also had regard to the one-year course on Managing Elderly Care (Level 7 Diploma) which you completed in June 2022. The panel noted that it was not clear from the certificate provided whether this course was accredited by a university or a Higher Education Institute. Mr Oyegoke was also unable to clarify this.

The panel took into account that you had worked as a nurse under a conditions of practice order for approximately a year. The panel also considered the evidence about your performance at your current workplace. It heard from Witness 5, your current line manager at the Home and accepted that no concerns have been raised about your competence and conduct at the Home. It also had regard to your professional development plan at the Home and noted that apart from the duty of candour, you have been signed off as competent.

Further, the panel had regard to the positive testimonials/references attesting to your good character. It noted that these included character references from non-work colleagues that spoke highly of you. The panel attached limited weight to these character references as they could not attest to your behaviour or practice whilst at work. The panel also considered the two testimonials from your former colleagues. It noted that you worked with one of these colleagues on the Ward in 2018/2019 whilst you were under an informal capability process. It noted that you had worked with the other colleague '*more than ten times'* and that she was the nurse who you handed over the patient to, in charges 3b to 3e. The panel was not satisfied that it could give significant weight to these testimonials given the circumstances in which you had worked with these colleagues.

The panel accepted your evidence that your misconduct arose during a period where [PRIVATE]. It had regard to the [PRIVATE] evidence you provided and noted that you had [PRIVATE]. It also noted that, in 2019/2020, you [PRIVATE].

The panel acknowledged the evidence from [PRIVATE]. Further, it acknowledged the evidence from Witness 5 that you are supported and working well in your current workplace.

The panel determined that the majority of the concerns regarding your lack of competence and misconduct stem from underlying attitudinal and behavioural issues. The panel bore in mind that a number of the charges found proved, demonstrate that you rushed and/or were rough with patients, that you shouted at and/or acted in an aggressive manner towards colleagues and a patient, and that you behaved dishonestly. It noted that you were given a number of opportunities to improve your practice over a significant period of time including an informal capability process and an informal capability action plan. The panel was satisfied from the evidence that you were supported during this time. However, it determined that you failed to fully engage with this process as evidenced by your misconduct relating to charges 8 and 9.

In respect of misconduct, the panel had regard to the NMC guidance on 'Serious concerns which are more difficult to put right' (FTP-3a):

> *'A small number of concerns are so serious that it may be less easy for the nurse, midwife or nursing associate to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening.*
> *…*
> *We may need to do this where the evidence shows that the nurse, midwife or nursing associate is responsible for:*
>
> - *breaching the professional duty of candour to be open and honest when things go wrong, including covering up…'*

The panel noted that your misconduct included two instances of dishonesty whilst at work and behavioural issues including shouting at or being aggressive towards colleagues in response to feedback.

The panel also had careful regard to NMC guidance on 'Serious concerns which could result in harm if not put right' (FTP-3b). It identified your misconduct and lack of competence breached the four fundamental pillars of the nursing profession set out in the Code. The panel determined that the charges found proved demonstrated a pattern of incidents and repeated failures to prioritise patient safety, which indicated underlying attitudinal issues.

The panel also had regard to the NMC guidance on 'Serious concerns based on public confidence or professional standards' (FTP-3c).

The panel concluded that you had not sufficiently remediated the concerns with your lack of competence and misconduct. The panel was not satisfied that your insight into your lack of competence and misconduct was sufficiently developed. Although, the panel accepted that you had made some efforts to strengthen your practice and have been working without concerns at the Home, given the underlying attitudinal and behavioural concerns and the limited period of time that you have worked since the incident, it did not accept that you have remediated your practice.

The panel determined that there is a significant risk that you would repeat your misconduct or failings in the future. The panel was not satisfied that you can currently practise kindly, safely and professionally. The panel therefore decided that a finding of impairment is necessary on the grounds 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.

The panel determined that a finding of impairment on public interest grounds is also required because a reasonable and well-informed member of the public would be concerned if a nurse, who had been dishonest, lacked competency in a wide range of fundamental nursing skills and had behaved aggressively and shouted at colleagues and a patient, were not found impaired. It determined that public confidence in the nursing profession would be undermined, and standards would not be maintained if impairment were not found. Therefore, the panel 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 by reason of your lack of competence and misconduct, on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Danti submitted that, as your actions were found to have amounted to serious misconduct and a lack competence, these posed risks to public protection and the public interest.

Ms Danti emphasised that the panel must consider proportionality and fairly balance your rights and the NMC's overarching objective of public protection. The least restrictive sanction should be considered that protects the public and meets the public interest.

Ms Danti highlighted several aggravating factors, including dishonesty on two occasions, deliberately breaching the duty of candour and seeking to cover up when something went wrong, particularly when people receiving care are at risk of harm; wide-ranging concerns and repeated failures to prioritise patient safety; a pattern of misconduct and lack of competence that stemmed from underlying attitudinal issues; failure to engage in a capability process; insufficient and incomplete remediation and a lack of insight or accountability. She also referred to the panel's earlier finding that there were contradictions in your reflections, you minimised your misconduct and sought to shift blame to others.

Ms Danti referred the panel to the NMC guidance on seriousness (FTP-3), stating that dishonesty is always found to be serious, may be difficult to remediate and may warrant removal from the register, especially when it involves covering up errors that could harm patients. Ms Danti submitted that although there was no evidence of actual patient harm, your behaviour put patients at risk of harm.

Ms Danti also stated that the panel may consider mitigating factors, such as [PRIVATE] and that you had [PRIVATE]. However, she submitted that these did not mitigate the seriousness of the case.

Ms Danti submitted that taking no action or issuing a caution would be inappropriate due to the seriousness of the misconduct, your lack of competence and lack of insight into your failings and the on-going risk to patients. These sanctions would not protect the public or address the public interest in this case.

She also submitted that a conditions of practice order would not be appropriate or proportionate as the issues in this case are too widespread to be addressed by retraining

alone and involve dishonesty and attitudinal issues that could hinder a conditions of practice order.

Ms Danti submitted that the NMC had originally indicated to you in its case management form that it would be making a 'sanction bid' for a suspension order. However, this was before you had given evidence, before the panel heard from witnesses and before the panel's decision on facts and impairment. She submitted that it was now the NMC's position that a suspension order would only protect patients while you were suspended and would fail to satisfy the public interest. She submitted that a well-informed member of the public would be deeply shocked and concerned and would lose trust and confidence in the NMC and nursing profession if a suspension order were imposed.

Ms Danti invited the panel to consider a striking-off order. She submitted that this was the only sanction that would fully protect the public, maintain professional standards, and uphold trust and confidence in the nursing profession and its regulator.

Prior to making his submissions in response to Ms Danti, Mr Oyegoke submitted a document containing an updated employment reference letter from the Manager at the Home, dated 9 September 2024, together with two further training certificates.

Mr Oyegoke, in his submissions on your behalf, emphasised that the purpose of a sanction is not punitive but to protect the public and uphold the public interest, while also considering your rights and livelihood. He also highlighted the principle of proportionality, stressing the need to balance public protection with your ability to continue practising in your chosen profession which you have committed so many years to.

Mr Oyegoke acknowledged that the panel found you currently impaired. Mr Oyegoke invited the panel to take a holistic approach, taking into account all the evidence before it including the updated reference from your employer and your remediation. Mr Oyegoke submitted that the purpose of a sanction is to protect the public and also to bring a registrant back to safe practice.

Mr Oyegoke referenced the case of *PSA v NMC (SM)* [2017] CSIH 29 and submitted that this Scottish case involved dishonesty of a registrant and the panel in that case had not found impairment and considered that the registrant had been punished enough. He also addressed the NMC's proposal in the case management form which sought a 12-month suspension. He submitted that the case had evolved significantly, with several charges dismissed or amended, therefore, making a lesser sanction more appropriate.

Mr Oyegoke submitted that the panel should consider sanctions from the least restrictive to the most severe, starting with options such as taking no further action or a caution order, progressing to a conditions of practice order and further if necessary. Mr Oyegoke submitted that imposing a conditions of practice order was an appropriate sanction.
Mr Oyegoke invited the panel to consider that you admitted many charges at the outset and engaged fully with the process. He also submitted that you had demonstrated remorse and insight. Further, he emphasised that you are continuing to practise under an interim conditions of practice order without any further incidents and you are supported by positive references from your current employer. Mr Oyegoke concluded by inviting the panel to impose a conditions of practice order, submitting that this sanction would protect the public and allow you to return to safe practice under supervision and further remediate your practise.

Ms Danti provided a response to Mr Oyegoke's submission regarding the reference letter from your current employer and the training certificates. She submitted that the updated reference, dated 9 September 2024, is nearly identical to an earlier one from the same individual, dated 5 March 2024, with only minor changes. She emphasised that the panel has already made its findings on impairment and should base its decision on those. She highlighted that while the recent reference mentions your completion of a duty of candour training, no certificate has been provided to the panel as evidence.

Ms Danti also addressed the two certificates which related to training in Arthritis and Obsessive-Compulsive Disorder. She submitted that this training is irrelevant to the

concerns about your practice. Ms Danti reaffirmed that the NMC's position is consistent and that it is within their right to adjust their recommendations on sanction based on developments in the case.

Mr Oyegoke clarified that the duty of candour training referenced in the updated employer reference is the same training previously highlighted to the panel.

In his final remarks, Mr Oyegoke submitted that your situation had changed slightly since April as you continued to work at the Home. He submitted that, despite the 'rigorousity' of the interim conditions of practice order you have been working under, you have been able to practise for 18 months and produce evidence of this. He submitted that your employer remains satisfied with your performance and is happy to engage you. This ongoing employment is a positive update compared to your shorter tenure at the time of the hearing in April.

Decision and reasons on sanction

The panel considered the updated employer reference, dated 9 September 2024, noting that you have been signed off on your PDP at the Home, particularly the section addressing the duty of candour, and your employer has no concerns regarding your current practice. The panel determined that the updated reference did not affect its earlier decision on impairment. The evidence of Witness 5, including the duty of candour training certificate and the PDP, were reviewed by the panel when making its decision on impairment.

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 and the NMC's guidance on 'How we determine seriousness' (FTP-3) and 'Considering sanctions for serious cases' (SAN-2). The decision on sanction is a matter for

the panel independently exercising its own judgement. The panel accepted the advice of the legal assessor.

The panel took into account the following aggravating features which it considered apply in this case:

- Your lack of insight into your failings (lack of competence, misconduct and dishonesty)
- You minimised your behaviours, sought to shift blame and did not acknowledge responsibility for your actions
- Your behaviour amounted to a pattern of misconduct and lack of competence over a significant period of time (between September 2018 and August 2020), which included:
  - Wide-ranging lack of competence in relation to patient safety
  - Multiple instances of aggression towards a patient and colleagues
  - Repeated dishonesty in a clinical setting where residents were vulnerable
  - Majority of the misconduct and lack of competence stemmed from underlying attitudinal issues
- Your conduct, which included failings in fundamental nursing skills, put patients at risk of suffering harm
- You failed to properly engage with the Trust's informal capability process

The panel also took into account the following mitigating features, which it considered apply in this case:

- You made early admissions to many of the charges
- Personal mitigation including [PRIVATE]

The panel referred to its earlier decisions regarding the seriousness of the facts found proved and the serious misconduct and lack of competence which led to its finding on impairment. It was satisfied that your misconduct, dishonesty and lack of competence amounted to wide-ranging and serious failings over a significant period of time. It

determined that your behaviour, which involved a deliberate breach of your professional duty of candour, including on an occasion when things had gone wrong, your aggression towards colleagues and a patient, and failings in patient safety, all indicated a dangerous attitude to the safety of vulnerable people receiving care.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case, and it would not protect the public. 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 misconduct and lack of competence were not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice order on your registration would be an appropriate and proportionate response. The panel is of the view that there may be practical or workable conditions that could be formulated to address some of the clinical concerns identified in relation to lack of competence. However, given your misconduct, in particular the dishonesty identified, the underlying attitudinal issues and your lack of insight into your failings, the panel concluded that workable conditions could not be identified to address the key aspects of this case. Therefore, the panel determined that a conditions of practice order would not adequately protect the public and would not be sufficient to address the public interest.

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:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *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 acknowledged that there was no evidence of repetition of your behaviour since the incidents. However, it was satisfied that most of the factors that indicated a suspension order were not applicable in this case for the following reasons:

- Your failings did not involve a single instance of misconduct. These were wide-ranging, occurred over a significant period of time (from September 2018 to August 2020) and included behaving in an aggressive manner towards a patient and colleagues, lack of compassion and regard for patient safety and a deliberate breach of your duty of candour.
- The majority of the charges found proved stemmed from harmful attitudinal issues.
- You lacked insight into your failings. There were contradictions within your reflections, you minimised the impact of your behaviour and attempted to shift blame to others.

Your misconduct and lack of competence, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel determined that your failings amounted to a serious breach of the fundamental tenets of the profession and are fundamentally incompatible with you remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

The panel went on to consider a striking-off order and took account of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel found that the regulatory concerns raise fundamental questions about your professionalism, in particular the attitudinal concerns arising from the repeated failures relating to duty of candour which involved attempts to shift blame and avoid accountability.

The panel concluded that your actions, in failing to treat vulnerable patients safely, professionally and with kindness were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with remaining on the register.

The panel took into account the [PRIVATE] you experienced during the period when the charges arose. However, the panel determined that these factors did not lessen the seriousness of the case, as the concerns were wide-ranging and extended over a significant period.

The panel determined that its findings demonstrate that your actions were so serious that to allow you to remain on the register would undermine the public's trust and confidence in the nursing profession, in the NMC as a regulatory body and in the standards expected of registered nurses.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel understands that this order will have an adverse effect on you but considers that it is necessary for the protection of the public, to maintain public trust and confidence in the profession and to send to the public and the profession a clear message about the standards of behaviour required of a registered nurse.

This decision will be confirmed to you in writing.

Interim order

As the striking-off 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 striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Danti. She submitted that the imposition of an interim suspension order to cover the appeal period until the substantive sanction takes effect and any appeal is resolved is necessary for the same reasons that the panel imposed the substantive sanction.

Ms Danti invited the panel to consider an interim suspension order for 18 months. This duration accounts for the possibility that an appeal may be lodged, and the NMC has no control over how long the High Court would take to resolve it.

The panel also took into account the submissions of Mr Oyegoke, who opposed the application for an interim suspension order on the grounds that you have been working without any issues or concerns since March 2023, indicating no new risk during the period before the substantive order takes effect.

Mr Oyegoke invited the panel to consider that an interim suspension order is not required. He emphasised the need for the panel to balance your interests against public interest and protection.

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 risks to patients and the public identified by the panel in its earlier decision and reasons for imposing the substantive order.

The panel had regard to Mr Oyegoke's submissions that you have practised without incident under the interim conditions of practice order. The panel noted that the interim

conditions of practice order was imposed by a panel that was undertaking a risk assessment prior to this substantive hearing at which the facts were established and your fitness to practise was found to be impaired.

The panel determined that an interim suspension order was necessary to protect the public and uphold public confidence in the nursing profession and to do otherwise would be incompatible with its earlier findings. The period of this order is for 18 months to allow for the possibility of an appeal to be made and concluded.

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

That concludes this determination.