Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 24 September 2024 – Monday 30 September 2024

Virtual Hearing

Name of Registrant:	**Elizabeth Bolanle Kehinde Edunsin**
NMC PIN	92Y0201O
Part(s) of the register:	Registered Nurse – RN1, Adult Nurse (January 1992) P298, Nursing Elderly People (January 1998)
Relevant Location:	Manchester
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, lay member) Janine Ellul (Registrant member) Paul Leighton (Lay member)
Legal Assessor:	Paul Housego (24 September 2024) Charles Conway
Hearings Coordinator:	Muminah Hussain
Nursing and Midwifery Council:	Represented by Grace Khaile, Case Presenter
Mrs Edunsin:	Not present and not represented
Facts proved:	Charges 1, 2, 3 & 4
Facts not proved:	Charge 5
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**

Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Edunsin was not in attendance and that the Notice of Hearing letter had been sent to Mrs Edunsin's registered email address by secure email on 19 August 2024.

Ms Khaile, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Edunsin's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Edunsin has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Edunsin

The panel next considered whether it should proceed in the absence of Mrs Edunsin. It had regard to Rule 21 and heard the submissions of Ms Khaile who invited the panel to continue in the absence of Mrs Edunsin.

Ms Khaile submitted that there had been no engagement at all by Mrs Edunsin with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Edunsin. In reaching this decision, the panel has considered the submissions of Ms Khaile and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Edunsin;
- Mrs Edunsin has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Three witnesses have been scheduled to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2023;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Edunsin in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own

behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Edunsin's decision to absent herself from the hearing.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Edunsin. The panel will draw no adverse inference from Mrs Edunsin's absence in its findings of fact.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Khaile under Rule 31 to allow the email from Assistant Manager 1 to Manchester Primary Care Partnership into evidence. Assistant Manager 1 was not present at this hearing and has not produced a witness statement. Ms Khaile submitted that the material is fair and relevant as it relates to charge 5. She submitted that the evidence is not sole and decisive, and another witness will speak to the 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 gave the application in regard to Assistant Manager 1 serious consideration. The panel determined that the evidence was not sole or decisive and it can be challenged. The panel also noted that there is a witness who can speak to the evidence, and the evidence does not seem to be fabricated.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Assistant Manager 1, but would give what it

deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Khaile, on behalf of the NMC, to amend the wording of the stem of charge 1.

It was submitted by Ms Khaile that the proposed amendment would provide clarity and more accurately reflect the evidence. Ms Khaile submitted that when looking at schedule 2, the later dates referred to are after Ms Edunsin had left her post at Charlestown Medical Practice, but this is not to say that she did not have access to certain files.

Ms Khaile proposed the following:

> "That you a registered nurse;
>
> ~~Whilst~~ **In respect of** working at Charlestown Medical Practice between 1 November 2022 – 23 February 2023;"

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

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

Details of charge

That you a registered nurse;

In respect of working at Charlestown Medical Practice between 1 November 2022 – 23 February 2023;

1) Failed to complete clinical records during/following a consultation, for one or more patients as set out in schedule 1.

2) Did not record clearly that you had documented a retrospective entry in the clinical records for one or more patients as set out in schedule 2.

Whilst working at Park View Medical Centre between 14 February – 16 May 2023;

3) Failed to complete clinical records during/following a consultation, for one or more patients as set out in schedule 3.

4) For one or more consultations did not record clearly that you had documented a retrospective entry in the clinical records.

Whilst working for the Northern General Practice Provider Organisation;

5) On or around 21/22 March 2023 incorrectly placed a smear test/sample for a patient behind a computer.

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

Schedule 1

Failed to complete clinical notes during/following a consultation;

1. On 8 November 2022 for Patient 1
2. On 8 November 2022 for Patient 4
3. On 9 November 2022 for Patient 5
4. On 9 November 2022 for Patient 6
5. On 16 November 2022 for Patient 7
6. On 16 November 2022 for Patient 8
7. On 30 November 2022 for Patient 9
8. On 30 November 2022 for Patient 10
9. On 30 November 2022 for Patient 11
10. On 30 November 2022 for Patient 12
11. On 6 December 2022 for Patient 13
12. On 6 December 2022 for Patient 14
13. On 6 December 2022 for Patient 15
14. On 6 December 2022 for Patient 16
15. On 6 December 2022 for Patient 17
16. On 6 December 2022 for Patient 18
17. On 6 December 2022 for Patient 19
18. On 7 December 2022 for Patient 20
19. On 7 December 2022 for Patient 21
20. On 7 December 2022 for Patient 22
21. On 13 December 2022 for Patient 23
22. On 13 December 2022 for Patient 24
23. On 13 December 2022 for Patient 25
24. On 13 December 2022 for Patient 26
25. On 13 December 2022 for Patient 27
26. On 14 December 2022 for Patient 28
27. On 14 December 2022 for Patient 29

28. On 20 December 2022 for Patient 30
29. On 20 December 2022 for Patient 31
30. On 20 December 2022 for Patient 32
31. On 20 December 2022 for Patient 33
32. On 20 December 2022 for Patient 34
33. On 20 December 2022 for Patient 35
34. On 21 December 2022 for Patient 36
35. On 21 December 2022 for Patient 1
36. On 28 December 2022 for Patient 37
37. On 28 December 2022 for Patient 38
38. On 28 December 2022 for Patient 39
39. On 3 January 2023 for Patient 40
40. On 3 January 2023 for Patient 41
41. On 3 January 2023 for Patient 42
42. On 3 January 2023 for Patient 43
43. On 4 January 2023 for Patient 44
44. On 4 January 2023 for Patient 1
45. On 4 January 2023 for Patient 45
46. On 10 January 2023 for Patient 46
47. On 10 January 2023 for Patient 47
48. On 10 January 2023 for Patient 43/48
49. On 10 January 2023 for Patient 49
50. On 10 January 2023 for Patient 50
51. On 10 January 2023 for Patient 51
52. On 11 January 2023 for Patient 52
53. On 11 January 2023 for Patient 53
54. On 11 January 2023 for Patient 54
55. On 11 January 2023 for Patient 55
56. On 11 January 2023 for Patient 56
57. On 11 January 2023 for Patient 57
58. On 11 January 2023 for Patient 58

59. On 17 January 2023 for Patient 59
60. On 17 January 2023 for Patient 60
61. On 17 January 2023 for Patient 61
62. On 17 January 2023 for Patient 62
63. On 17 January 2023 for Patient 63
64. On 17 January 2023 for Patient 64
65. On 17 January 2023 for Patient 65
66. On 18 January 2023 for Patient 66
67. On 18 January 2023 for Patient 67
68. On 25 January 2023 for Patient 68
69. On 1 February 2023 for Patient 69
70. On 1 February 2023 for Patient 70
71. On 1 February 2023 for Patient 71
72. On 1 February 2023 for Patient 72
73. On 1 February 2023 for Patient 73
74. On 1 February 2023 for Patient 74
75. On 1 February 2023 for Patient 75

Schedule 2

Did not document clearly that you had made retrospective entries in clinical records;

1. On 2 March 2023 for Patient 1
2. On 2 March 2023 for Patient 16
3. On 10 January 2023 for Patient 66
4. On 26 January 2023 for Patient 2
5. On 16 March 2023 for Patient 3.
6. On 30 March 2023 for Patient 3.

Schedule 3

Failed to complete clinical notes during/following a consultation;

1. On or around 1 March 2023 for Patient 76
2. On or around 1 March 2023 for Patient 77
3. On or around 1 March 2023 for Patient 78
4. On or around 7 March 2023 for Patient 79
5. Between 15-21 March 2023 for Patient 80
6. Between 15-21 March 2023 for Patient 81
7. On or around 21/22 March 2023 for Patient 82
8. On or around 28 March 2023 for Patient 83
9. On or around 5 April 2023 for Patient 84
10. On or around 5 April 2023 for Patient 85
11. On or around 5 April 2023 for Patient 86
12. On or around 11 April 2023 for Patient 87
13. On or around 11 April 2023 for Patient 88
14. On or around 11 April 2023 for Patient 89
15. On or around 11 April 2023 for Patient 90
16. Between 11-26 April 2024 for Patient 91
17. On or around 12 April 2023 for Patient 92
18. On or around 12 April 2023 for Patient 93
19. On or around 12 April 2023 for Patient 94
20. On or around 12 April 2023 for Patient 95
21. On or around 19 April 2023 for Patient 96
22. Between 19-25 April 2023 for Patient 97
23. Between 19-25 April 2023 for Patient 98
24. Between 19-25 April 2023 for Patient 99
25. On or around 2 May 2023 for Patient 100
26. On or around 2 May 2023 for Patient 101
27. On or around 2 May 2023 for Patient 102

28. Between 10-16 May 2023 for Patient 103
29. Between 10-16 May 2023 for Patient 104
30. Between 10-16 May 2023 for Patient 105
31. Between 10-16 May 2023 for Patient 106

Background

The NMC received a referral on 7 June 2023, by the head of service at Manchester Primary Partnership (the Trust).

The concerns regarding Mrs Edunsin's practice arose when she was working as an agency nurse at Charlestown Medical Practice (Charlestown), Park View Medical Centre (Park View), and for the Northern General Practice Provider Organisation (the Practice).

Charlestown

On 15 March 2023, Patient 3 attended Charlestown with their mother for an appointment for their third immunisation jab. However, the nurse clinician discovered that there were no clinical records of the patient's immunisation, which had taken place on 1 February 2023. Mrs Edunsin was contacted, and informed the Practise Manager that Patient 3's first immunisation was administered on 4 January 2023, and the second being on 1 February 2023.

Following this and other similar incidents, a full audit was conducted of the Mrs Edunsin's clinical records for appointments undertaken between November 2022 and February 2023. The findings revealed that 77 examples of patient appointments for which there were no corresponding clinical notes on record. It was also noted that Mrs Edunsin would complete clinical records of consultations more than a day after the appointments.

Park View

Mrs Edunsin worked at Park View as a locum practice nurse from 14 February 2023 to 16 May 2023.

An audit was undertaken due to concerns regarding Mrs Edunsin's record keeping. Records were noted as being missing for consultations carried out on numerous occasions on numerous days. It was noted that she failed to carry out adequate record keeping of 31 patients. Mrs Edunsin had also failed to record that clinical records had been completed retrospectively.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Edunsin.

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: Practice Operations Manager at Charlestown.

- Witness 2: Practice Operations Manager at Park View.
- Witness 3: Head of Service for Northern Health General Practitioner Provider Organisation.

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

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

Charge 1

"That you a registered nurse;

In respect of working at Charlestown Medical Practice between 1 November 2022 – 23 February 2023;

1) Failed to complete clinical records during/following a consultation, for one or more patients as set out in schedule 1."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's written statement and oral evidence, and the full audit of patients seen by Mrs Edunsin between 8 November 2022 – 1 February 2023.

The panel firstly determined that Mrs Edunsin had a duty to complete clinical records during/following a consultation. Witness 1 explained in her oral evidence that it was

expected of an agency nurse to complete records following a consultation. She informed the panel that the need to complete records was not outlined to Mrs Edunsin specifically as this was a known duty and expected of all staff. The panel noted that there was evidence of Mrs Edunsin completing other clinical records following consultations.

Witness 1's written statement reads:

> *"… I decided to audit every consultation that Elizabeth had undertaken between November 2022 and February 2023. I began undertaking the audit on 31 March 2023 and recorded it as a significant event …*
>
> *I asked [Assistant 1] to go through all of Elizabeth's consultations. We discovered 77 examples of consultations from 8 November 2022 to 1 February 2023 for which Elizabeth had not completed a consultation record at the time of the consultation."*

Witness 1 confirmed the above in her oral evidence.

The panel had regard to the full audit of patients seen by Mrs Edunsin between 8 November 2022 and 1 February 2023. It found that Mrs Edunsin had failed to complete clinical records during/following a consultation for all of the dates set out in Schedule 1 apart from 1.44, 1.51 and 1.68 which it found not proved for the following reasons:

- Schedule 1.44 refers to Patient 1 on 4 January 2023, but there was not a Patient 1 on the audit sheet for this date.
- Patient 51 (schedule 1.51) had an appointment on 10 January 2023, and the consultation record on the audit sheet indicates that the consultation record was added on 10 January 2023 in the '*Date Consult Added'* column.
- Patient 68 (schedule 1.68) had an appointment on 25 January 2023, and the consultation record on the audit sheet indicates that the consultation record was added on 26 January 2023 in the '*Date Consult Added'* column.

Witness 1's written statement reads:

> *"A TEAMS meeting was held with Elizabeth on 16 May 2023… When I stated that we had found 77 records that had not been completed, Elizabeth said "What?". When I confirmed the number, she said "Jesus". She appeared to be very surprised by the news. She did not provide any explanation for how this might have happened."*

The panel noted that Mrs Edunsin was made aware of the number of records that had not been completed, but she did not respond at the time.

The panel found Witness 1's evidence to be cogent and clear, and considered her to be a credible witness. It determined that her evidence, as well as the full audit which was produced soon after the events, proved that between 1 November 2023 and 23 February 2024 Mrs Edunsin had failed to complete clinical records during/following a consultation, for one or more patients as set out in schedule 1.

The panel therefore finds charge 1 proved.

Charge 2

"That you a registered nurse;

> In respect of working at Charlestown Medical Practice between 1 November 2022 – 23 February 2023;
>
> 2) Did not record clearly that you had documented a retrospective entry in the clinical records for one or more patients as set out in schedule 2."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's written statement and oral evidence, the full audit of patients seen by Mrs Edunsin between 8 November 2022 and 1 February 2023, and the audit trail for notes added at a later date.

Witness 1's written statement reads:

> *"… for two consultations that took place on 6 December 2022, Elizabeth added the consultation records on 2 February 2023. Elizabeth also edited three appointments some time after the initial record was made, such as appointments that took place on 10 January 2023 and was edited on 8 February 2023. When consultations are written retrospectively, the nurse should include a note that the record was written in retrospect.*
>
> *For a period of time, it would not have been clear for any clinicians looking at these patients' records that a consultation taken place. There was also nothing to indicate that, when the records were added or amended, they had been written retrospectively. There was therefore a risk that they mislead the reader into believing that the records were made contemporaneously."*

The panel referred to the full audit of patients seen by Mrs Edunsin between 8 November 2022 and 1 February 2023, and the audit trail for notes added at a later date. The panel could not identify any evidence relating to retrospective entries for patients in schedule 2.1, 2.3 and 2.4. However, it determined that schedule 2.2, 2.5 and 2.6 had retrospective entries and that Mrs Edunsin had not clearly recorded that they were written at a date after the consultation date.

The panel therefore finds charge 2 proved.

Charge 3

"That you a registered nurse;

Whilst working at Park View Medical Centre between 14 February – 16 May 2023;

3) Failed to complete clinical records during/following a consultation, for one or more patients as set out in schedule 3."

This charge is found proved.

In reaching this decision, the panel took into account the audit for Mrs Edunsin's consultations between February and May 2023, Mrs Edunsin's job description for Park View, and Witness 2's written statement and oral evidence.

The panel firstly determined that Mrs Edunsin had a duty to complete clinical records during/following a consultation. Witness 2 explained in her oral evidence that it was expected of an agency nurse to complete records following a consultation. She informed the panel that the need to complete records was not outlined to Mrs Edunsin specifically as this was a known duty and expected of all staff. The panel noted that there was evidence of Mrs Edunsin completing other clinical records following consultations.

The panel referred to the audit for Mrs Edunsin's consultations between February and May 2023. It found that barring schedule 3.24 and 3.28, the rest of the schedule was proved. Schedule 3.24 did not have a Patient 99 evidenced in the audits. 3.28 had two Patients 103 with the same medical conditions on the same date and one of the consultations had been written up; the panel determined that on the balance of probabilities, 3.28 was not proved.

Mrs Edunsin's job description for Park View stated:

"11. To maintain accurate patient records and enter onto the computer using agreed Read Codes

12. Ensure accurate completion of all necessary documentation associated with patient health care"

Witness 2's written statement reads:

"I sent Elizabeth a copy of my audit and asked her to come in the following day with any paperwork she had for the missing records. She mentioned again about the computer crashing but again I was not aware of any issues with the computer. She did not pass any paperwork to me."

In her oral evidence, Witness 2 confirmed that there had been no issues raised by other members of staff about the computers. The panel found Witness 2's evidence to be cogent and clear, and considered her to be a credible witness.

The panel therefore finds charge 3 proved.

Charge 4

"That you a registered nurse;

Whilst working at Park View Medical Centre between 14 February – 16 May 2023;

4) For one or more consultations did not record clearly that you had documented a retrospective entry in the clinical records."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, and the audit for Mrs Edunsin's consultations between February and May 2023.

Witness 2's written statement reads:

> *"For 31 of the consultations I reviewed… These records were not marked as being completed retrospectively. There was therefore a risk that these records would mislead the reader that had been completed contemporaneously."*

The panel referred to the audit for Mrs Edunsin's consultations between February and May 2023. It noted that:

- a consultation on 15 February 2023 was not added on the consult record until 21 February 2023;
- a consultation on 21 February 2023 was not added on the consult record until 17 May 2023;
- a consultation on 7 March 2023 was not added on the consult record until 5 May 2023;
- a consultation on 11 April 2023 was not added on the consult record until 18 April 2023, and;
- another consultation on 11 April 2024 was not added on the consult record until 26 April 2023.

The panel determined that Witness 2 was a credible witness. It determined that on the balance of probabilities, there was no reason to doubt Witness 2 or the evidence set out in the audit schedules.

The panel therefore finds charge 4 proved.

Charge 5

"That you a registered nurse;

> Whilst working for the Northern General Practice Provider Organisation;

5) On or around 21/22 March 2023 incorrectly placed a smear test/sample for a patient behind a computer."

This charge is found NOT proved.

In reaching this decision, the panel took into account the lack of evidence that the NMC had provided. It was of the view that this charge was based mainly on hearsay evidence coming from Witness 3 and the emails. The panel determined that a smear test/sample for a patient was left behind a computer, but there was insufficient evidence from which the panel could infer on the balance of probabilities that Mrs Edunsin had placed it there.

The panel therefore found charge 5 NOT proved.

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 misconduct and, if so, whether Mrs Edunsin's 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 misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Mrs Edunsin's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (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 Khaile invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Submissions on impairment

Ms Khaile moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Khaile submitted that Mrs Edunsin's actions related to two separate incidents at two different practices. She submitted that Mrs Edunsin has not provided any insight into her actions, and had not engaged in the hearing to speak to her case.

Ms Khaile submitted that impairment can be found on the grounds of public protection and public interest, as members of the public would lose confidence in the profession if these concerns were not pursued by its regulator.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mrs Edunsin's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Edunsin's actions amounted to a breach of the Code. Specifically:

> *'1.2 make sure you deliver the fundamentals of care effectively*
>
> ***10 Keep clear and accurate records relevant to your practice***
>
> *10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> *10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*
>
> ***20 Uphold the reputation of your profession at all times***
>
> *20.1 keep to and uphold the standards and values set out in the Code'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that a fundamental aspect of the nursing

profession is record keeping, and Mrs Edunsin failed to document clear records in a timely manner.

The panel found that Mrs Edunsin's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Edunsin's fitness to practise is currently impaired.

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

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

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

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

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

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

…'

The panel found the three limbs above in the Dame Janet Smith test engaged. The panel finds that patients were put at risk and could have been caused physical harm as a result of Mrs Edunsin's misconduct. Mrs Edunsin's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel had nothing before it to suggest that Mrs Edunsin had demonstrated sufficient insight. It had regard to the registrant's response bundle, and noted that Mrs Edunsin had not provided a reflective piece on her failings or on what she could do in the future to ensure these failings do not happen again. Witness 2 informed the panel in her oral evidence that without proper records, there is a risk of harm to patients and other colleagues. The panel determined that Mrs Edunsin had not completed numerous records for a vast number of patients, even retrospectively.

The panel considered the positive testimonial that Mrs Edunsin had provided and was of the view that this was of limited value in assisting the panel, as it did not speak to the charges that were found proved.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Edunsin has taken steps to strengthen her practice. The panel took into account the training on documentation and record keeping that Mrs Edunsin had undertaken in June 2023. The panel determined that although Mrs Edunsin had provided documentation on relevant training that speaks to the charges, it had no evidence of how she has used this to strengthen her practice.

The panel is of the view that there is a risk of repetition as Mrs Edunsin has not provided the panel with any evidence that she can practice safely and professionally. The panel found that the incidents took place over a number of months, and involved many patients in two separate practices. It also noted that it had no information on Mrs Edunsin's current practice and no evidence that she can practice safely. 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.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Edunsin's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Edunsin's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mrs Edunsin's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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 Khaile informed the panel that the NMC had advised Mrs Edunsin that it would seek the imposition of a 12 month conditions of practice order if it found Mrs Edunsin's fitness to practise currently impaired.

Ms Khaile submitted that the seriousness of the misconduct in this case means that taking no action or imposing a caution order would be inappropriate. Ms Khaile submitted that a conditions of practice order would sufficiently address the record keeping failures and clinical record keeping errors. She submitted that the charges are not so serious to

warrant a suspension order. Ms Khaile submitted that a suspension order or striking off order would not be appropriate in this manner, but that under conditions, Mrs Edunsin would be able to continue practising safely.

Ms Khaile submitted that the aggravating features are:

- The charges arise from two separate practices in terms of record keeping
- There has been no insight from Mrs Edunsin as she has not engaged with this hearing

Ms Khaile submitted that there are no mitigating features.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- No engagement with this hearing
- Lack of insight and reflection
- A pattern of misconduct over a period of time, involving two separate GP practices
- Conduct which put patients at risk of suffering harm

The panel found no mitigating features.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Edunsin's 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 Mrs Edunsin's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel had regard to the fact that other than these incidents, Mrs Edunsin has had an unblemished career of many years as a nurse. The panel also noted that it was only in a minority of cases that records had not been completed by Mrs Edunsin. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Edunsin should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mrs Edunsin's case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will protect the public, mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> 'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must limit your practice to one clinical employer.

2. You must have a workplace supervisor who will audit your record keeping entries on a weekly basis

3. Before your next review hearing, you must produce a reflective piece which focuses on:
   - The importance of comprehensive record keeping
   - The significance and impact of not maintaining appropriate records

4. You must send the NMC a report before your next review hearing from your line manager / supervisor / mentor, detailing your record keeping performance.

5. You must keep us informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

6. You must keep us informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).
   c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

8. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well Mrs Edunsin has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Mrs Edunsin's engagement with the NMC.
- Testimonials from Mrs Edunsin's colleagues regarding her practice.

This will be confirmed to Mrs Edunsin in writing.

Submissions on interim order

The panel took account of the submissions made by Ms Khaile. She submitted that a conditions of practice order would be appropriate.

The panel heard and accepted advice from the legal assessor.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months.

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

That concludes this determination.