Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 11 - Thursday 14

&

Tuesday 19 - Wednesday 20 April 2022

Virtual Hearing

Nursing and Midwifery Council

Name of registrant:	Mrs Adedehinbo Olusile
NMC PIN:	88A0113O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – June 2001
Area of Registered Address:	England
Type of case:	Misconduct
Panel members:	Judith Webb (Chair, lay member) Diane Gow (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	Martin Goudie QC
Hearings Coordinator:	Dylan Easton
Nursing and Midwifery Council:	Represented by Jessica Bass, Case Presenter
Mrs Olisule:	Present and represented by Alison Hollis, of Counsel, instructed by the Royal College of Nursing (RCN)

Facts proved:	Charges 1a, 1b, 1c, 1d, 2a, 2b, 2c, 2d, 4
Facts not proved:	Charge 3
Fitness to practise:	Impaired
Sanction:	Caution Order (18 months)
Interim order:	N/A

Details of charges

That you, a registered nurse:

1) On an unknown date, in or around January 2017, after Colleague 1 reported an allegation of assault on Resident A by Colleague 2:

    a) Failed to escalate the allegation.

    b) Failed to complete an incident form.

    c) Failed to record the allegation in Resident A's records.

    d) Told Colleague 1 not to mention or tell anyone about the allegation or words to that effect.

2) On an unknown date, in or around May 2017, after Colleague 1 reported an allegation of assault on Resident A by Colleague 2:

    a) Failed to escalate the allegation.

    b) Failed to complete an incident form.

    c) Failed to record the allegation in Resident A's records.

    d) Told Colleague 2 that Colleague 1 had reported the allegation to you.

3) Your conduct in Charges 1 and/or 2, above, deliberately or otherwise put the interests of Colleague 2 ahead of the interests of Resident A.

4) Your conduct in Charge 1 and/or 2, above, was a breach of your professional duty of candour in that you sought to prevent Colleague 1 from raising a patient safety concern and/or you failed to escalate a patient safety concern.

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

Decision and reasons on application for hearing to be held in private (1)

During Colleague 1's evidence, Ms Hollis made a request that this case be held partially in private on the basis that proper exploration of your case involves reference to the health of Colleague 1. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Miss Bass indicated that she supported 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 determined to go into private session in connection with Colleague 1's health as and when such issues are raised in order to protect their right to privacy.

Decision and reasons on application for hearing to be held in private (2)

During your evidence, Ms Hollis made a request that this case be held partially in private on the basis that proper exploration of your case involves reference to the health of your family member. The application was made pursuant to Rule 19.

Miss Bass indicated that she supported 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 determined to go into private session in connection with your family member's health as and when such issues are raised in order to protect your right to privacy.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Hollis, who informed the panel that you made full admissions to charges 2a, 2b and 2c. During oral evidence, you made a partial admission with regards to charge 4.

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 Miss Bass on behalf of the NMC and by Ms Hollis.

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:

- Colleague 1: Colleague 1 was a Health Care Assistant at Elmwood Care Home at the time of the incidents
- Mr 1: Mr 1 was the Home Manager from May 2017 at Elmwood Care Home

The panel also heard live evidence from you under oath.

Background

The allegations against you arose whilst you were employed as a registered nurse at Elmwood Care Home ("the Home"). The allegations mainly relate to concerns that you failed to escalate two reports you received from Colleague 1, about allegations of physical abuse on a resident (Patient A) at the Home by Colleague 2.

At the time of the first allegation, Colleague 1 was a new health care assistant (HCA) shadowing Colleague 2, who was a senior HCA. You were the nurse in charge of the shift.

It is alleged that, in January 2017, Colleague 1 witnessed Colleague 2 apply Patient A's body cream into her hands and slapped the cream strongly on his face and proceeded to clench her fist and hit Patient A on the head.

Colleague 1 reported the incident of the alleged physical abuse to you on the same day. It is alleged that you told Colleague 1 not to mention or report the incident to anyone. It is alleged that you failed to escalate the report to the

Home's manager, complete an incident form or record the alleged physical abuse in Patient A's records.

In May 2017 Colleague 1 heard another incident of possible abuse by Colleague 2 and again reported this to you on the same day, but again this was not escalated or recorded. On this occasion, you allegedly told Colleague 2 about reports being made by Colleague 1, thereby leaving a patient at risk and seeking to cover up potential abuse. Colleague 2 accompanied by another colleague then challenged Colleague 1, who was left feeling unsupported and singled out.

On 22 May 2017, Colleague 1 wrote a formal written complaint to the Home's manager that included the January 2017 incident she had witnessed. The Home's manager made a safeguarding referral on 5 June 2017, and a safeguarding case conference was convened on 22 August 2017.

It is agreed that no records were made by anyone of either the abuse or any reports made by the healthcare assistant.

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

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

Charges 1a, 1b and 1c:

"That you, a registered nurse:

1) On an unknown date, in or around January 2017, after Colleague 1 reported an allegation of assault on Resident A by Colleague 2:

a) Failed to escalate the allegation.

b) Failed to complete an incident form.

c) Failed to record the allegation in Resident A's records."

These charges are found proved.

In reaching this decision, the panel took into account the evidence in this case and considered the witnesses in respect of the credibility and reliability of their accounts, their character, demeanour and how their oral evidence aligns with the documentary evidence before it. The panel considered the complaint letter submitted by Colleague 1, dated 22 May 2017, record of safeguarding meeting in August 2017, transcripts of the previous hearing from 2019 and the agreed facts.

The panel considered Colleague 1's evidence and it is of the view that they are a credible witness. The panel found Colleague 1's evidence particularly useful with regards to charge 1 and it noted that, despite rigorous cross examination, there was no ambiguity or change as to the nature of the incident which occurred in January 2017. The panel is of the view that the information which Colleague 1 set out was both credible and logical. The panel acknowledged some inconsistencies in Colleague 1's testimony over time but it was of the view that there were plausible explanations provided to the panel and the main elements of Colleague 1's account has remained consistent.

As such, the panel determined that charges 1a, 1b and 1c are found proved with the combination of Colleague 1's evidence and also the documentary evidence, namely the of letter 22 May 2017 and the safeguarding conference meeting notes dated 22 August 2017.

Charge 1d:

> "d) Told Colleague 1 not to mention or tell anyone about the allegation or words to that effect."

This charge is found proved.

In reaching its decision the panel considered the oral evidence from you and Colleague 1.

In considering charge 1d, the panel find it proved both on evidence from Colleague 1 and also the fact that the action of telling a colleague not to disclose an incident of this nature would be a plausible action for someone to do in your position. It is of the view that this would not necessarily be to cover up such an incident but rather, if the incident were to be investigated, it would have to remain confidential.

Charges 2a, 2b and 2c:

> "On an unknown date, in or around May 2017, after Colleague 1 reported an allegation of assault on Resident A by Colleague 2:
>
> a) Failed to escalate the allegation.
> b) Failed to complete an incident form.
> c) Failed to record the allegation in Resident A's records"

These charges are found proved.

The panel noted that you had admitted these charges, but in doing so had admitted them on the factual basis that related to the incident that the panel has found took place and was reported to you in January 2017, see charge 1. In evidence, you did

not accept that Colleague 1 had reported to you a second incident concerning a slap to Resident A in May 2017. Therefore, whilst noting the admissions from an evidential perspective, the panel does not take the admissions into account as formal admissions to charges 2a, 2b and 2c under Rule 24(5).

The panel considered that there are similar factors in play relating to these charges as in charge 1. It took into account Colleague 1's evidence about an incident of alleged abuse against Resident A taking place in May 2017. It considered the evidence from you and also had regard to Colleague 1's complaint letter, dated 22 May 2017 as well as the safeguarding conference meeting notes from August 2017.

The panel took into account the written representations made on your behalf casting doubt on where in the Home Colleague 1 reported concerns to you. However, it considered that the overall time frame supported Colleague 1's allegation of an incident occurring in May 2017 followed by an altercation with Colleagues on 20 May 2017, an intervention by Mr 1 allowing Colleague 1 to go home early followed by a complaint letter from Colleague 1 on the 22 May 2022.

In light of this, the panel is of the view that charges 2a, 2b and 2c are found proved.

Charge 2d:

"d) Told Colleague 2 that Colleague 1 had reported the allegation to you."

This charge is found proved.

In reaching its decision, the panel relied on the oral testimony of Colleague 1 and on her complaint letter of 22 May 2017 and had particular regard to the following:

> *'As an after effect of my mentioning of the above incidents to* [you]*, on 20/05/2017,* [Colleague 2] *and* [another healthcare assistant] *called me inside a room and* [Colleague 2] *shouted at me saying why you report the above incidents to higher level and that they may lost everything if I continue with these complaints.'* [Sic]

The panel discounted that Colleague 2 could have found out by another route, the only other option was conversations Colleague 1 was said to have had with other colleagues on another floor in the Home. These conversations are said to have taken place in January whilst this confrontation took place after she made the report to you in May.

The panel considered all of the evidence and find charge 2 proved in its entirety, not on the basis of the admissions by you but on the basis of the evidence given by Colleague 1 and documentary evidence regarding the incident which occurred in May 2017.

Charge 3:

> "3) Your conduct in Charges 1 and/or 2, above, deliberately or otherwise put the interests of Colleague 2 ahead of the interests of Resident A."

This charge is found NOT proved.

In reaching its decision, the panel has considered all of the evidence before it and it considered your experience and the pressures you would face in your job, especially

concerns about staffing levels at the Home and your difficult personal circumstances which you outlined in your oral evidence.

The panel considered that there are a number of potential reasons as to why charges 1a, 1b and 1c and charges 2a, 2b and 2c did not take place, but it cannot find, on the balance of probabilities, that you were deliberately putting the interests of Colleague 2 above the interests of Resident A.

Similarly for the reasons regarding charges 1d and 2d, the panel does not find that there was anything done by you which would be considered improper. It determined that your actions are those of which the panel would expect you to take given your role. Whilst you made Colleague 2 aware of what Colleague 1 had said, the panel is of the view that this was not done necessarily to protect Colleague 2 but as part of dealing with the concern raised with you in May 2017.

Charge 4:

> "4) Your conduct in Charge 1 and/or 2, above, was a breach of your professional duty of candour in that you sought to prevent Colleague 1 from raising a patient safety concern and/or you failed to escalate a patient safety concern.

This charge is found proved as follows:

Your conduct in Charge 1 and/or 2, above, was a breach of your professional duty of candour in that you failed to escalate a patient safety concern.

In reaching its decision in respect of charge 4, the panel took into account its findings in respect of charges 1 to 3. It finds charge 4 proved in relation to the failure to escalate patient safety concerns.

In reaching its decision, the panel considered the admissions you made in respect of a report made by Colleague 1 to you regarding the January 2017 incident. For the reasons already set out in charge 2, the panel does not accept that admission as a formal admission.

Through your failings on charges 1 and 2, you failed in your professional duty of candour and there was a specific failure to escalate the patient safety concerns through any of the routes available. However, whilst charge 1d has been found proved, for the reasons set out, the panel does not find it proved on the basis you were seeking to prevent Colleague 1 from raising the patient safety concern.

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all

the circumstances, your 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.'*

The panel had sight of the following written submissions on misconduct from Miss Bass:

*"**Preamble***

1. *The panel will be aware that in deciding whether a Registrant's fitness to practise is impaired by reason of misconduct the correct course (per Cheatle v General Medical Council [2009] EWHC 645) is to embark upon a two stage process.*

2. *First, the panel should consider whether the facts found proved amount to misconduct.*

3. *In determining this questions there is no burden or standard of proof, it is entirely a matter for the panel's professional judgment (per Council for the Regulation of Health Care Professionals v (1) General Medical Council (2) Biswas [2006] EWHC 464 (Admin)).*

Misconduct

4. *The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 provide assistance when seeking to define misconduct:*

'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of

propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances'.

5. *The panel may further be assisted by the comments of Elias LJ in R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin) who stated that misconduct must be 'sufficiently serious that it can properly be described as misconduct going to fitness to practise'.*

The Code

6. *Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) is, in my submission, to be answered by reference to the Nursing and Midwifery Council's Code of Conduct.*

7. *I submit that the following parts of the Code are engaged and have been breached by the Registrant:*

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

To achieve this, you must:

…

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
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

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

16 Act without delay if you believe that there is a risk to patient safety or public protection
To achieve this, you must:
16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
…
16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so
16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern
16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

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

20.4 keep to the laws of the country in which you are practising

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

8. *The misconduct in this case is twofold. Firstly, Ms Olusile failed to follow correct procedure on hearing of possible abuse of a patient on two occasions and secondly in doing so, she breached her duty of candour.*

9. *Failing to escalate and record the reports of abuse against a vulnerable patient left that patient at risk of harm for a number of months. If the patient had been safeguarded after the report in January, arguably, the concern in May could have been avoided entirely.*

10. *All healthcare professionals have a duty of candour, this is a professional responsibility to be open and honest when things go wrong. Not only is it specifically referenced in the Code, there is also guidance specifically on this duty which focuses not only on the duty to be open and honest with patients but also on the need to be open and honest within organisations in reporting adverse incidents or near misses that may have led to harm.*

Ms Olusile in all the circumstances of this case, departed from good professional practice and the facts as found are sufficiently serious to constitute misconduct."

The panel also had sight of Ms Hollis' written submissions on misconduct which are as follows:

"The charges that have been found proven by the panel amount to:

a. *Failing to escalate or record allegations, and complete incident forms as required (Charges 1a, 1b, 1c, 2a, 2b, and 2c);*

b. *Telling a colleague not to mention the allegation to anyone else (although not to cover up an incident) (1d and 2d); and*

c. *Breaching the duty of candour, albeit on the basis that there was a specific failure to escalate the patient safety concerns through any of the routes available, not on the basis that the Registrant was seeking to prevent a colleague from raising the patient safety concern (4).*

Ms Hollis submitted that your fitness to practice is not currently impaired.

The Law

The panel will undoubtedly be aware that fitness to practice hearings are governed by the Nursing and Midwifery Order 2001 (the "Order") and the Nursing and Midwifery Council (Fitness to Practice) Rules 2004 (the "Rules").

There is no burden or standard of proof when considering misconduct and impairment – they are both matters for a panel's professional judgment. The primary purpose of fitness to practice proceedings are to protect the public.

> *"Misconduct*
>
> *'Misconduct' is a term which is not defined in the Order or the Rules.*
>
> *The courts have, on various occasions, sought to define the term. In the case of Roylance, it was said:*
>
> *"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious".*
>
> *In R (Calhaem) v General Medical Council, Jackson J stated that:*

"The word 'misconduct' in [MA 1983] section 35C(2)(a) does not mean any breach of the duty owed by a doctor to his patient: it connotes a serious breach which indicates that the doctor's fitness to practise is impaired."

Following a review of the authorities, His Lordship derived five principles relevant to that case, which involved failures by a consultant anaesthetist and departure from Good medical practice in the context of a serious operation. These are:

a. *Mere negligence does not constitute 'misconduct' within the meaning of section 35C(2)(a) of the MA 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to 'misconduct'.*

b. *A single negligent act or omission is less likely to cross the threshold of 'misconduct' than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as 'misconduct'.*

c. *'Deficient professional performance' within the meaning of section 35C(2)(b) is conceptually separate both from negligence and from misconduct. It does not mean any instance of sub-standard work. It connotes a level of professional performance which indicates that the doctor's fitness to practise is impaired. It is unacceptably low which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.*

d. *A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute 'deficient professional performance'.*

e. *It is neither necessary nor appropriate to extend the interpretation of 'deficient professional performance' in order to encompass matters which constitute 'misconduct'.*

The charges, as found proven by the panel, amount largely to your negligence, or failure to act, rather than any specific action you took. In those circumstances, the following case law may assist.

In Nandi v General Medical Council, Collins J adopted the observation of Lord Clyde in Rylands v General Medical Council that:

"… professional misconduct is 'a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious'. The adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree."

Whether the facts as found amount to misconduct is a matter for the panel's professional judgment."

Submissions on impairment

Miss Bass 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

The panel had sight of Miss Bass' written submissions which are as follows:

"***Impairment***

11. *If the panel finds the facts found proved do amount to misconduct the next matter the panel must consider is whether the Registrant's fitness to practise is currently impaired by reason of that misconduct.*

13. *Impairment is conceptually forward looking and therefore the question for the panel is whether Ms Olusile is impaired as at today's date (per Cohen also Zgymunt v General Medical Council [2008] EWHC 2643 (Admin)).*

14. *The panel should note that, in line with rule 31(7)(b) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, a departure from the Code is not of itself sufficient to establish impairment of fitness to practise, that question, like misconduct is a matter for the panel's professional judgment.*

15. *I submit that the panel is likely to find the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) helpful. Those questions are :*

    1. *has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
    2. *has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
    3. *has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future.*
    4. *has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.*

16. *In my submission the first three questions can be answered in the affirmative in respect of past conduct.*

17. *Current impairment can be found either on the basis that there is a continuing risk or that the public confidence in the nursing profession and the NMC as regulator would be undermined if such a finding were not made.*

18. *Duty of candour is a fundamental tenet of the profession, it is essential that nurses are open and honest when things go wrong both for the protection of patients and to maintain public confidence in the profession and to uphold proper professional standards. A breach of the duty of candour is sufficient to warrant a finding of current impairment on public interest grounds alone.*

19. *With regard to future risk, the panel will likely find assistance in the questions asked by Silber J in Cohen, namely, is the misconduct easily remediable, has it in fact been remedied and is it is highly unlikely to be repeated.*

20. *As to the risk of repetition, Ms Olusile has demonstrated remorse before you in this hearing and in her written reflections. She has explained that she has learnt a lot since the incidents and has explained that the conduct was a result of a lapse in judgement due to feeling under pressure at work and at home. Ms Olusile explained that she now works in a very supportive environment and does not experience the same pressures that she did at the time of the events described in the charges. In questioning, Ms Olusile said that it was what she had learnt and not the supportive working environment that has resulted in a lack of repetition but there was very little explanation as to what that means in practical terms. I would invite the panel to consider whether Ms Olusile has done enough to persuade you that the actions/omissions would not be repeated should she find herself similarly in a position where she felt under pressure.*

21. *Further, breaching the duty of candour is not only a breach of a fundamental tenet of the profession, it is also described in NMC guidance as a serious concern which is more difficult to put right. Without any proper*

explanation of how the failings came to be repeated in January and May 2017, and how you can be satisfied that it would not be repeated again, I submit that the breach of duty of candour has not been remedied and repetition is a very real possibility.

22. *For all the reasons detailed above, I submit that a risk of repetition remains and the registrant's actions, particularly the breach of the duty of candour, are so serious that a finding of current impairment is required in order to protect the public and to maintain public confidence in the profession and to uphold proper professional standards.*

The panel also had sight of Ms Hollis' written submissions on your behalf which are as follows:

"Impairment

'Impairment' is also a term which is not defined in either the Order or the Rules.

The purpose of fitness to practise proceedings is not to punish the registrant for past wrongdoings but to protect the public or profession where a registrant's current fitness to practise is impaired. Past conduct is a factor which can be taken into account, but panels should also take into account other relevant factors, such as whether the conduct in question is easily remediable, whether it has been remedied, and the likelihood of repetition.

If the panel concludes that Mrs Olusile's conduct does amount to misconduct, it is respectfully invited to find that Mrs Olusile's fitness to practice is not currently impaired for the following reasons:

a. *A period of over five years has elapsed since the conduct leading to the charges occurred. In that time, Mrs Olusile has reflected on the events that occurred between January – May 2017, and has completed*

many training courses in order to prevent future incidents (selection of training certificates provided at Registrant's Bundle p.2 – 6).

b. *She has had an exemplary career spanning over 34 years which is otherwise unblemished.*

c. *Throughout the duration of these proceedings, she has continued to work as a nurse without restriction and without any cause for concern. Her employers are aware of these proceedings and are fully supportive.*

d. *She has demonstrated genuine remorse and learned from her mistakes.*

1

The nature of the conduct and the circumstances in which it was committed make it unlikely that it will be repeated. The circumstances at Elmwood at the time were difficult – there were concerns about staffing levels at the home, and Mrs Olusile was exceptionally busy with a large number of responsibilities. Her difficult personal circumstances at home compounded with the challenging circumstances at Elmwood led to the failures occurring. These circumstances are unlikely to arise again, but in the event that similar circumstances arose, Mrs Olusile said she has learned from this experience and now has a good foundation and a good understanding of what she should and shouldn't do.

PUBLIC INTEREST FACTORS

Professional Standards

It is accepted that there is a public interest in maintaining public confidence in the profession and declaring and upholding proper standards of conduct.

Mitigation focuses on what Mrs Olusile has done to address any concerns about her practice.

Valuable Contribution to the Profession

There is a strong public interest in retaining a person who is able to make (and in this case, is making) a valuable contribution to the nursing profession.

Aside from Mrs Olusile's otherwise unblemished 34-year record of practice, further evidence of her valuable contributions to the profession is found in the testimonials written on her behalf.

a. *Mrs Rekha Govindan, Registered manager at Chegworth Nursing Home (Registrant's Bundle, p. 7 and 8). Mrs Govindan has known Mrs Olusile in a professional capacity for around 20 years, and has "always had opportunity to observe Adedehinbo's practice...she is a very good communicator, very polite, professional to deal with…Many relatives officially mentioned and expressed their gratitude that how well Adedenhinbo looked after their loved ones." Her documentation is "accurate, precise, and informative, and always leave reports at my desk in my absence". She says that "due to previous experience, Adedehinbo is always one step ahead of reporting any incidents regardless of how small the matter is". In addition, Adedehinbo always "offers help and support to junior staffs and does conduct staff supervision. There was no single concern raised about Adedehinbo all these years...and she is well known among the staff for her attitude, professionalism, and helping hand." In her opinion, Mrs Olusile is "100% fit to practice as registered nurse without restriction" and it would be a loss if her name is removed from the register.*

b. *Ms Damilola Olusile, daughter (currently a GP trainee) (Registrant's Bundle, p.9). "My mum has been a nurse for over 30 years and takes so much pride in her job and profession. She is efficient, caring and meticulous about her job. She is very knowledgeable, polite, and has good communication with people all around her. She is always ready to*

offer help…Her colleagues often sing her praise and tell me how lucky I am to have such a caring mum".

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Insight and Remediation

It should be clear from Mrs Olusile's oral and written evidence that she has reflected and holds a high degree of insight into her conduct. She has also demonstrated clear remorse.

Despite the prolonged nature of these proceedings, and the stress that has inevitably resulted from them, Mrs Olusile has maintained her professionalism.

Conclusion

It is submitted that in the circumstances, Mrs Olusile has demonstrated sufficient insight and has taken steps to address any concerns arising from the incidents. It is also submitted that the risk of repetition in the future is reduced. She has an otherwise positive professional record, including an absence of any other concerns from past or current employers, and has not been the subject of any previous regulatory proceedings. She has engaged throughout the process.

The panel is respectfully invited to find that:

a. *Mrs Olusile's actions do not amount to misconduct; or*
b. *That her fitness to practice is not currently impaired."*

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code as outlined in Miss Bass' submissions.

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 the breaches in the Code, especially parts 16, 17 and 25, had been repeated, in both January and May 2017, and had over a period of months the potential to cause harm to a vulnerable resident.

The panel found that your 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, 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 and to uphold the duty of candour. 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*

d) *…*

The panel finds that patients were put at risk as a result of your misconduct. Further, it determined that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered that, in your oral evidence, you demonstrated an understanding of what you would do differently next time. It also noted that you apologised and showed remorse for your misconduct. However, the panel

determined that you demonstrated limited insight into how your actions put patients at risk of harm. It took into account your reflective pieces, dated 2019 and 2022 and it noted that both reflective pieces are similar in content despite having been written three years apart.

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 you have taken steps to strengthen your practice. The panel took into account the mandatory and voluntary training which you have undertaken as seen in your training certificates.

The panel also considered that you are currently practising as a nurse full-time at Chegworth Nursing Home and have done so without concern since 2018 as stated in testimonials from the Registered Manager. These testimonials from 2019 and 2022 also included many positive aspects about your current nursing practice and how you currently perform in the areas of concern, with particular reference to your ability to escalate concerns.

When considering public protection, the panel took into account that you have worked at Chegworth Nursing Home for a prolonged period of time without concern and also took into account the Registered Manager's positive testimonial. It also noted that, in your oral evidence, you told the panel that Chegworth is nominated for an RCN award for Outstanding Nursing Homes. The panel determined that the conduct of the kind found proved is highly unlikely to be repeated. The panel therefore decided that a finding of impairment is not 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.

When considering the wider public interest, the panel determined that confidence in the nursing profession would be brought into disrepute should a fully informed member of the public learn that a junior colleague had raised concerns with you about the abuse of a vulnerable patient, and nothing was done despite the concerns having been raised in both January and May 2017. The panel took into account the Code, with particular regard to parts 16, 17 and 25 and it concluded that your misconduct in breach of these parts of the Code engage the public interest.

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 finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel considered this case very carefully and decided to make a caution order for a period of 18 months. The effect of this order is that your name on the NMC register will show that you are subject to a caution order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Miss Bass informed the panel that in the Notice of Hearing, dated 9 March 2022, the NMC had advised you that it would seek the imposition of a suspension order for a period of 4 months with a review if it found your fitness to practise currently impaired. However, Miss Bass informed the panel that this is incorrect due to an administrative error on the part of the NMC and she apologised for this. The NMC revised its proposal and submits that a suspension order for a period of 6 months with a review is the appropriate order.

The panel had sight of written submissions from Miss Bass which are as follows:

“

1. *The panel should bear in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive, may have such consequences. The panel should have careful regard to the sanctions guidance. The decision on sanction is a matter for the panel independently exercising its own judgement.*

2. *The aggravating features of the case are:*

    - *Repeated misconduct*
    - *Misconduct that placed a vulnerable patient at a risk of harm*
    - *Limited insight*

3. *The mitigating features of the case are:*

    - *Personal mitigation including both pressures at work and in their private life*
    - *Efforts to put things right with recent relevant training*

4. *Taking the available sanctions in turn, the panel will first consider taking no action. It would be rare to make a finding of impairment and then impose no sanction and this case is not one of those rare cases. A vulnerable patient was put at risk of harm and a breach of fundamental tenets of the profession warrants action being taken.*

5. *A caution order is the least serious sanction in that it is the least restrictive. Sanctions guidance states a caution order is only appropriate if the panel has decided “there’s no risk to the public or to patients requiring the nurse or midwife’s practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise…”. The panel have already found that a vulnerable patient was put at risk of harm and that Mrs Olusile has breached fundamental tenets of the profession, it therefore cannot be*

said to be at the lower end of the spectrum and a caution would be insufficient.

6. *You have the power to impose conditions of practice for up to three years, and that would allow Mrs Olusile to work as a nurse. Sanctions Guidance provides a non-exhaustive list of factors which may indicate that conditions are appropriate, which includes :*
   - *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*
   - *potential and willingness to respond positively to retraining*
   - *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*
   - *conditions can be created that can be monitored and assessed.*
7. *There are no clinical concerns which more obviously lend themselves to remedy by way of conditions of training or supervision. In cases such as this, which include a breach of the duty of candour, it is very difficult, if not impossible, to formulate conditions which would address the misconduct.*

8. *You have the power to impose a suspension order for up to one year. A suspension order would normally be reviewed before its expiry. The sanctions guidance provides a checklist as a guide to help you decide whether it's appropriate or not, which includes :*
   - *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*

9. *This case is serious and relates to repeated misconducted that placed a vulnerable patient at a risk of harm as well as a breach of the duty of candour. The panel have already have found there was no malicious intent so it would be difficult to argue there is a harmful deep-seated attitudinal problem. There is no evidence of repetition since the incidents. He panel have already decided there is not a significant risk of repetition. The NMC say that a suspension for six months would protect the public and meet the public interest requirement, and a review would give Mrs Olusile an opportunity to develop, and demonstrate her insight, which the panel have described as limited.*

10. *You do of course have the power to impose a striking off order.*

11. *Sanctions guidance on strike off advises :*

    Before imposing this sanction, key considerations the panel will take into account include:

    - *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?*

12. *Mrs Olusile's actions cannot be said to be fundamentally incompatible with being on the register. In my submission a strike off is not the only sanction that would be sufficient to protect the public and maintain confidence in nurses and it would therefore be disproportionate at this stage.*

13. *For all of the reasons above, the appropriate and proportionate sanction is that of a six month suspension order with a review."*

The panel also had sight of written submissions from Ms Hollis which are as follows:

"Background

1. The charges that have been found proven by the panel amount to:

a. Failing to escalate or record allegations, and complete incident forms as required (Charges 1a, 1b, 1c, 2a, 2b, and 2c);
b. Telling a colleague not to mention the allegation to anyone else (although not to cover up an incident) (1d and 2d); and
c. Breaching the duty of candour, albeit on the basis that there was a specific failure to escalate the patient safety concerns through any of the routes available, not on the basis that the Registrant was seeking to prevent a colleague from raising the patient safety concern (4).

2. The panel has found that the charges do amount to serious professional misconduct and that Mrs Olusile's practice is currently impaired on the grounds of public interest. It has decided that a finding of impairment is not necessary on the grounds of public protection.

The Law

3. The panel will undoubtedly be aware that fitness to practice hearings are governed by the Nursing and Midwifery Order 2001 (the "Order") and the Nursing and Midwifery Council (Fitness to Practice) Rules 2004 (the "Rules").

4. The panel should have regard to the NMC's guidance 'Factors to consider before deciding on sanctions' (updated 29/11/2021) ("SAN-1") which sets out the approach to be taken, although each case should be decided on its own facts.

Proportionality

5. Sanctions must be proportionate to the misconduct proved. In applying the principle of proportionality, panels should weigh the interests of the public with those of the registrant. The penalty must be proportionate to the breach and all of the circumstances.

6. The panel should start with the sanction with the least impact on Mrs Olusile's practice, and consider whether that would be sufficient to satisfy the public interest. If it is not sufficient, only then should they go on to consider the next most serious sanction. When the panel finds the sanction that is enough to achieve that, then it has gone far enough.

7. It is also important to remember that the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise.

8. In Brennan v. Health Professions Council [2011] EWHC 41 (Admin), Ouseley J said that, where the purpose of sanction is to deal with issues other than the primary one of maintaining public safety, and is instead to provide deterrence to others, to maintain confidence in the profession's reputation and standards, and in the regulatory process, the reasoning is particularly important in showing that the sanction is proportionate to the misconduct and for the individual.

Aggravating features

9. SAN-1 sets out a list of possible aggravating features:

a. Previous regulatory/disciplinary findings: There are no previous regulatory or disciplinary findings arising out of anything other than this incident.

b. Abuse of a position of trust: there was no abuse of a position of trust beyond that which is inherent in any nursing position of employment.

c. Lack of insight into failings: Mrs Olusile accepts that the panel has found she has demonstrated limited insight into how her actions put patients at risk of harm.

d. A pattern of misconduct over a period of time: Although the panel has found there were two occasions when Mrs Olusile failed to escalate concerns (January and May 2017), it is submitted they should be viewed as 'one-off failings' during a long career.

e. Conduct which put patients at risk of suffering harm: It is conceded that failure to escalate the concerns raised put Resident A at risk of suffering harm. Mitigating features

10. SAN-1 sets out three categories in which mitigating features might fall:
a. Insight and understanding
b. Following good practice
c. Personal mitigation. Insight and Understanding

11. The panel has had sight of reflective pieces written by Mrs Olusile in 2019 and 2022. The testimonial of Ms Govindan explains how she has applied this learning to her practice: "Due to previous experience, Adedehinbo is always one step ahead of reporting any incidents regardless of how small the matter is".

12. Mrs Olusile has attended relevant training courses, including annual mandatory training, along with an additional course on the duty of candour.

Following good practice

13. The panel has testimonials from Rekha Govindan, Registered Manager of Chegworth Nursing Home, who is Mrs Olusile's current employer. She gave an initial testimonial in 2019 and has updated it in 2022. She speaks very

highly of Mrs Olusile, and says that not only are there no concerns in relation to her nursing practice, but she is a valuable member of the team.

14. She has practiced successfully and without incident for 5 years following these incidents, and although she has not completed a period of supervised practice targeted at the concerns arising from her conduct as found, she does frequently work closely together with Ms Govindan, who has found no concerns with her practice. This period of practice took place in the same clinical setting (nursing home) as the one in which the concerns arose. She gave evidence of a time following the incident when she did have to escalate a report that had been made. Her current employer is fully aware of the areas of concern with Mrs Olusile's practice, and has observed that there are no further concerns.

Personal mitigation

[PRIVATE]

17. Any inability to work would affect her financially to her detriment and deprive her of her right to a livelihood in her chosen profession.

Delay

18. The panel will of course have in mind that the conduct leading to these charges took place some 5 years ago. These proceedings have been hanging over Mrs Olusile for a lengthy period of time and the panel is invited to consider that as a relevant factor when considering sanction.

19. In particular, an intelligent and informed member of the public may be more accepting of a lesser sanction with the knowledge that some 5 years have elapsed between the time of conduct and time of sanction.

Other factors

20. In its notice of hearing, the NMC notified the Registrant and her legal representatives that, if the charges were found proven, it would request a specific sanction of a 4-month suspension order without review. On 19 April 2022, after the panel had handed down its determination on the facts and after hearing evidence on impairment, the NMC communicated to the Registrant's legal representative that in fact the specific sanction contained on the notice of hearing had been inserted incorrectly, and in fact the NMC would be requesting a 6-month suspension order, with a review. This is notwithstanding the fact that the panel found charge 3 not proved, and charges 1d, 2d, and 4 were found proved to a lesser extent than the NMC alleged.

21. The first two of the NMC's values are "We're fair. We treat everyone fairly. Fairness is at the heart of our role as a trusted, transparent regulator and employer" and "We're kind. We act with kindness and in a way that values people, their insights, situations and experiences". The panel is invited to consider whether it is fair and kind to retrospectively increase the sanction sought following a hearing in circumstances when nothing further has come to light during proceedings, and the charges have not been found proved in their entirety.

Appropriate Sanction

22. The panel may first consider taking no action. Bearing in mind the findings previously made by this panel, the Registrant accepts this would be an unusual course of action.

23. The next sanction to be considered by the panel would be a caution order. It is submitted that a caution order is appropriate in this case. The panel is invited to have regard to the NMC's guidance on Caution Orders (Ref: SAN-3b) which states that caution orders are appropriate where the FTP Committee has decided there is no risk to the public or to patients requiring the nurse's practice to be restricted. The Panel has found in this case that the conduct concerned in this case is highly unlikely to be repeated and that no

finding of impairment was necessary on the grounds of public protection. It is submitted that a caution order would serve to mark the fact that the behaviour was unacceptable and must not happen again.

24. It is also submitted that a caution order would be the most proportionate sanction, taking into account all the relevant factors, and balancing the interests of the public with the interests of Ms Olusile. A caution order has serious consequences for a registrant since any current or prospective employer will need to be informed of its existence, and the order will be recorded on the register and therefore be in the public domain. It would serve as a warning to Mrs Olusile, while also meeting the high public interest in allowing an experienced nurse with an otherwise good record to continue practicing. It is submitted that this is the correct order to make in order to balance all the interests.

25. While the panel has found that a vulnerable patient was put at risk of harm and that Mrs Olusile has breached fundamental tenets of the profession, the purpose of a sanction is not to punish past misconduct but to prevent future misconduct and uphold public confidence in the profession. It is submitted that a caution order would achieve this.

26. If the panel considers that a caution order would not be sufficient to meet the public interest, the next most severe sanction would be a conditions of practice order. However, in circumstances where conduct of the kind found proved is highly unlikely to be repeated, and there is no risk to public protection, it is difficult to formulate a set of conditions that would be relevant to the public interest alone.

27. The next most severe sanction would be a suspension order. It is submitted that the imposition of a suspension order would be disproportionate in all the circumstances. While the case is serious, it is submitted that it is not so serious that nothing less than a suspension order would be sufficient. The panel has found that conduct of the type found proved is highly unlikely to be repeated. It has been 5 years since it occurred, and there has been no

repetition. A suspension order would also have the effect of removing Mrs Olusile from practice, which could have the unintended effect of setting her back, bearing in mind that she is currently in a very supportive environment, and receiving very positive feedback from colleagues and residents alike. It would also remove from practice a highly experienced nurse who is highly unlikely to repeat conduct of the kind found proved at a time when there is a great demand for experienced nurses.

28. If, notwithstanding the above, the panel decides that a suspension order is the lowest sanction required to meet the public interest, it is invited to keep the length as short as possible.

29. The panel does have the power to make a striking off order. There is no suggestion this is necessary or proportionate in this case.

[…]

Conclusion

33. The panel has found that a sanction is called for on the basis of public interest rather than public protection. The panel must therefore identify the least onerous sanction that an intelligent and informed member of the public would not consider insufficient. In considering that, the panel should bear in mind that any sanction will indicate to the public that the conduct has been taken seriously and has been dealt with.

34. It is submitted that a caution order is the sanction which properly balances the interests of the public and the interests of the Registrant, bearing in mind the following factors:
a. That a finding of impairment was not necessary on the grounds of public protection;
b. That there is a high public interest in experienced nurses being allowed to remain in practice;

c. It has been 5 years since the conduct occurred and the Registrant has been practicing successfully and without further incident in the time since;
d. That she has taken steps to address concerns by undertaking training;
e. That the Registered Manager of the nursing home in which she currently works has spoken highly of her skills and value;
f. That there has been a significant delay in bringing these proceedings to a conclusion, and that delay has caused a great deal of stress to the Registrant;
g. That removing her from practice could have the unintended consequence of setting back her professional development and skills which is inimical to what any sanction ought to be seeking to achieve."

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance (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:

- Lack of full insight into your misconduct.
- Failure on two occasions to properly action complaints made to you.
- Conduct which put vulnerable residents at risk of suffering harm.

The panel also took into account the following mitigating features:

- You made some admissions at the outset of the hearing and a further admission during the evidence stage.
- You apologised for your actions and demonstrated remorse.
- You have taken some steps to strengthen your practice with some additional training in the areas of concern.

- Your difficult personal circumstances that you were facing at the time of the incidents.
- The positive testimonials from your current Registered Manager at the Chegworth Nursing Home spanning five years.

The panel also took into account the following relevant circumstances when considering sanction:

- The difficult working environment at the Home, including frequent change in management and staffing issues, the work culture of the Home wherein staff were not working as a team. The Care Quality Commission (CQC) conducted inspections of the Home on 2 August 2016 and 12,15, and 18 September 2017 in the preparation of two reports. In both reports, among other things, they told the provider to take action because there were no "procedures in place to deploy sufficient numbers of suitably qualified, competent and skilled staff to cover routine and emergency work at the service".
- Your lengthy service as a nurse without any other findings against you since 1988.
- Your work over the five years since your misconduct.
- The passage of five years between the misconduct and the panel considering sanction.

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 public interest concerns identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 noted that you made some admissions and apologised to this panel for your misconduct, showing evidence of genuine remorse. It further considered that you have engaged with the NMC throughout the process.

The panel carefully considered whether to impose a more restrictive sanction and looked at a conditions of practice order. It considered the submissions from both Miss Bass and Ms Hollis, and it concluded that when all the circumstances of your misconduct, your career before and after the misconduct and the time period since the misconduct are taken into account, that a conditions of practice order would not be appropriate. In reaching that decision, the panel gave careful consideration as to what conditions could be imposed that would satisfy solely the public interest concerns in this case.

The panel, taking into account the submissions from the NMC, further considered a suspension order. The panel considered, for the reasons set out above, that a suspension order would be wholly disproportionate in this case. The panel considered that the public interest was not served by suspending a nurse who had shown remorse, taken some steps to strengthen their practice, evidence that she had learnt from the misconduct and was highly regarded by the management in her current role five years after the misconduct. The panel accepted that the misconduct was serious but considered that a suspension order was not proportionate in all the circumstances.

The panel has decided that a caution order would adequately protect the public. For the next 18 months, your employer - or any prospective employer - will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of 18 months would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse. The panel considered, given the effect these proceedings have already had on you, that the caution order

would provide a further period during which you should continue to reflect on your misconduct and strengthen your practice.

At the end of the 18-month caution order the note on your entry in the register will be removed. However, the NMC will keep a record of the panel's finding that your fitness to practise had been found impaired. If the NMC receives any further allegation that your fitness to practise is impaired, the record of this panel's findings and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to you in writing.

That concludes this determination