Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
4-7 and 31 January 2022

Virtual Hearing

Name of registrant:	**Inemesit Inyang**
NMC PIN:	04F0563O
Part(s) of the register:	Registered Nurse- Mental Health (June 2004)
Area of registered address:	Middlesex
Type of case:	Misconduct
Panel members:	Avril O'Meara (Chair, Lay member) Laura Scott (Registrant member) Anne Rice (Lay member)
Legal Assessor:	Gareth Jones
Hearings Coordinator:	Holly Girven
Nursing and Midwifery Council:	Represented by Mary Ellen Stewart, Case Presenter
Mr Inyang:	Present and represented by Dr Abbey Akinoshun
Facts proved by admission:	Charge 1
Facts proved:	Charge 2b, Charge 3 in respect of Charge 2b
Facts not proved:	Charges 2a and 2c
Fitness to practise:	Impaired
Sanction:	Suspension order (6 months)
Interim order:	Interim suspension order (18 months)

Decision and reasons on application to admit reflective statement

The panel heard an application made by Ms Stewart under Rule 31 to allow the reflective statement referred to in Charge 2c into evidence. She submitted that the reflective statement is clearly relevant to Charge 2c and it would be fair to admit it into evidence. Ms Stewart further informed the panel that Patient A would not be giving evidence and that their witness statement is no longer part of the Nursing and Midwifery Council's (NMC) evidence.

Dr Akinoshun submitted that he had no objection to the reflective statement being admitted into evidence, or to Patient A's witness statement being removed from 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 admit further evidence.

The panel gave the application in regard to the reflective statement serious consideration. The panel considered that Charge 2c refers to the reflective statement and determined that it would not be possible to determine whether Charge 2c was proved or not proved without considering the reflective statement. The panel determined that the reflective statement was relevant.

The panel considered whether you would be disadvantaged by the admission of the reflective statement. The panel determined that you would not be disadvantaged by the reflective statement being admitted, and further noted that Dr Akinoshun did not object to the reflective statement being admitted.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the reflective statement.

The panel also noted that Patient A's statement is no longer relied on by the NMC. The panel therefore had no regard to Patient A's statement when reaching its decision on the charges.

Details of charge

That you a registered nurse:

1) On 29 July 2018 whilst conducting 1:1 observations on Patient A, fell asleep during the course of your shift; (**Found proved by admission**)

2) On 30 July 2018 having reported an incident in relation to Patient A:

    a) completed a Datix report with inaccurate information; (**Found not proved**)

    b) did not provide Colleague 1 with an accurate handover; (**Found proved**)

    c) submitted a reflective statement in which you provided an inaccurate account of the incident that occurred; (**Found not proved**)

3) Your actions at Charge 2(a), (b) and (c) above were dishonest as you knew that you had fallen asleep whilst conducting 1:1 observations on Patient A and had sought to mislead your colleagues. (**Found proved in respect of Charge 2b**)

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

Decision and reasons on facts

At the outset of the hearing, the panel heard from Dr Akinoshun, who informed the panel that you admit to Charge 1.

The panel therefore finds Charge 1 proved in its entirety, by way of your admissions.

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

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

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

- Colleague 1: Clinical Team Lead on the Linden Unit (the Unit) in July 2018;
- Ms 2: Bank Support Worker on shift at the Unit at the time of the incident.

The panel also heard evidence from you under affirmation.

Background

The charges arose whilst you were working as a registered nurse on the Unit, an acute mental health inpatient unit for adults. You were employed through ACI Training and Consultancy Ltd (the Agency).

The charges relate to the night shift of 29-30 July 2018, during which you were the nurse in charge. At around 23:00, you were observing Patient A, who required level three observations, which meant Patient A should have remained in your eyesight at all times. It is alleged that you fell asleep whilst you were observing Patient A. Patient A took a video

of you whilst you were asleep. Patient A subsequently applied a ligature to their neck, which another staff member noticed before you did. You assisted to remove the ligature, and in the process of the ligature being removed, Patient A's NG tube came out.

You subsequently completed an incident form, and it is alleged you completed this with inaccurate information in that you omitted to state that you fell asleep during observations. You handed over to Colleague 1, who was the nurse in charge on the morning of 30 July 2018. It is alleged that you did not inform Colleague 1 that you had fallen asleep whilst observing Patient A and told Colleague 1 that it was dark and Patient A was covered up when they applied the ligature.

You completed a reflective statement for the Agency following the incident. It is alleged that in this reflective statement you did not mention that you had provided an inaccurate account of events to Colleague 1 during handover and on the incident form.

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

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

Charge 2a

2) On 30 July 2018 having reported an incident in relation to Patient A:

    a) completed a Datix report with inaccurate information;

This charge is found not proved.

In reaching this decision, the panel took into account the Datix report you completed and the evidence from you and Colleague 1. You told the panel that you had completed the

report in a way that was '*patient centred'* and explained to the panel which sections of the report you had completed. You stated that you did not complete the section '*Underlying causes or events'*. You said this section was sometimes completed by a manager once an incident had been investigated.

The panel considered that the report is brief and lacked detail as to what had happened. The panel considered that you gave a credible and reliable account of how you had completed the report and the panel determined that the information in the report was consistent with the other documentary evidence, the evidence of Ms 2 and your oral evidence. The panel accepted that your approach had been to complete the report in a '*patient centred*' way and you had not included information about your conduct in it.

The panel considered Colleague 1's evidence. She stated that she would have expected the report to contain more detail but that it was difficult to say whether the report was inaccurate. Colleague 1 stated that it would be best practice to include that you fell asleep in the report, but that this was not a requirement. She stated that the underlying causes section would have been the place to include that information but acknowledged that this section is sometimes left for a manager to complete once an investigation has taken place. She told the panel that she had completed this section, in September 2018, following the investigation of the incident.

The panel noted that it has not been provided with any guidance or policies that outline what should have been entered in the report by you.

The panel carefully considered all the evidence and was satisfied that although brief, the information you included in the report was accurate, and there is insufficient evidence before the panel that you were under an obligation to include in the report that you had fallen asleep. The panel therefore found this charge not proved.

Charge 2b

2) On 30 July 2018 having reported an incident in relation to Patient A:

b) did not provide Colleague 1 with an accurate handover;

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Colleague 1, including Colleague 1's written account in an email dated 13 August 2018.

Colleague 1 was clear and consistent in her oral evidence that you did not inform her that you had fallen asleep whilst observing Patient A. The panel considered that this information was of such importance that had you provided Colleague 1 with that information during handover, she would have remembered that you did so. The panel noted that Colleague 1's written account of 13 August 2018 supports Colleague 1's oral evidence that she only found out you had fallen asleep when Patient A informed her and showed her a video of you sleeping. The panel determined that Colleague 1's evidence that you did not inform her about this was consistent, credible and reliable.

The panel noted that you stated in your evidence that you told Colleague 1 that you '*might have dosed off*'. However, the panel considered that your evidence was not clear in this regard and lacked credibility.

The panel considered that Colleague 1 stated that she would have expected you to inform her you had fallen asleep when you informed her that Patient A had applied a ligature as this was relevant information. The panel determined that you should have provided Colleague 1 with an accurate handover before leaving the Unit, including the information that you had fallen asleep.

The panel determined that you did not tell Colleague 1 that you had fallen asleep.

The panel went on to consider whether you had stated to Colleague 1 that Patient A was able to ligature because it was dark, she was under blankets, not engaging with you and whether you implied that she had been in bed, not in the ladies lounge.

Colleague 1 relied on the email of 13 August 2018 when giving her oral evidence and acknowledged that she did not have a clear recollection of what exactly you had said to her. The panel took account of the other evidence available, including the Datix report and your oral evidence. It noted that in the report you had stated the location of the incident was the ladies lounge. The panel considered that it was unlikely that you would have given Colleague 1 information that suggested Patient A was in the bedroom, in the dark, covered in blankets. The panel considered that Colleague 1's evidence in this regard was not as reliable and therefore the panel determined that there was insufficient evidence to find this element of the charge proved.

This charge is therefore found proved solely on the basis that you did not inform Colleague 1 that you fell asleep when you should have done so.

Charge 2c

2) On 30 July 2018 having reported an incident in relation to Patient A:

    c) submitted a reflective statement in which you provided an inaccurate account of the incident that occurred;

This charge is found not proved.

In reaching this decision, the panel took into account that the part of the reflective statement completed by the Agency, which is what you were responding to, states:

> *'The worker was on a 1:1 with a female high risk patient. Whilst he was asleep the patient recorded him but then went on to ligature... The worker*

completed an incident form but it was completely different from what actually happened –he was asleep!'

The panel noted that in the reflective statement, you accept that you fell asleep as you state:

'*I believe I must have dozed off at some point subconsciously.'*

The panel considered that the reflective statement does not state that you did not accurately complete the incident form or handover to Colleague 1. The panel considered that by finding Charge 2a not proved it has found that the incident form was not inaccurate.

The panel noted that the reflective statement does mention the incident form and handover as you state:

'Incident form was completed. Incident was handed over and I was very apologetic about the incident.'

The panel considered that the reflective statement is not inaccurate and makes reference to you falling asleep. The panel noted that the description completed by the Agency makes no reference to an inaccurate handover. The panel determined that a reflective statement is a personal document and it is up to you to decide what aspects of an incident you accept, and choose to subsequently reflect on.

This charge is therefore found not proved.

Charge 3

3) Your actions at Charge 2(a), (b) and (c) above were dishonest as you knew that you had fallen asleep whilst conducting 1:1 observations on Patient A and had sought to mislead your colleagues.

This charge is found proved in respect of Charge 2b only

The panel considered that it has found Charges 2a and 2c not proved and as such determined that Charge 3 is not proved in relation to those two charges. The panel considered whether your actions at Charge 2b were dishonest.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of *Ivey v Genting Casinos UK Ltd t/a Crockfords* [2017] UKSC 67:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts…. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel first considered the actual state of your knowledge or belief at the time you provided Colleague 1 with the handover. The panel considered that at the time of handing over to Colleague 1, you were aware you had fallen asleep whilst observing Patient A. The panel also considered, based on your evidence, that it was likely that Patient A applied the ligature whilst you were asleep. The panel also considered that you are an experienced nurse and so would have known, or believed, that you should have informed Colleague 1 that you were asleep. The panel considered that in your oral evidence you stated that you told Colleague 1 that you '*might have dosed off*', and although the panel found you had not said this to Colleague 1, the panel determined that in stating this is what you said, you demonstrated an awareness that you should have provided this information to Colleague 1 during the handover.

The panel then went on to consider whether your conduct was dishonest by applying the standards of ordinary decent people. The panel determined that ordinary, decent people

would find it dishonest to deliberately omit telling Colleague 1 during the handover that you had fallen asleep when you knew that you should have done so.

As such, this charge is found 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 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.'*

Ms Stewart 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.

Ms Stewart submitted that your actions were extremely serious, and caused Patient A, a vulnerable patient, to experience actual harm. Further, she stated that not telling Colleague 1 that you had fallen asleep could have caused further harm to Patient A.

Dr Akinoshun stated that you accept that your actions amount to misconduct.

Submissions on impairment

Ms Stewart 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.

Ms Stewart submitted that you have not yet remediated your misconduct. She submitted that the references and reflective statement provided refer mainly to the fact that you fell asleep, as opposed to your dishonest conduct. She stated that your actions caused Patient A to experience actual harm. She stated that whilst your reflective statement does address dishonesty, this is limited. She submitted that in the statement you do not accept that you acted dishonestly, merely stating that you accept the panel's finding.

Dr Akinoshun submitted that your fitness to practise is not currently impaired. He informed the panel that you have worked since the incident, with no restrictions on your practice, and no further concerns have been raised about you. He submitted that the charges are a one-off incident, in an otherwise unblemished career, and although you do not seek to excuse that you fell asleep, you had explained the circumstances in which this had happened. He referred the panel to your updated reflective statement, which you provided following the panel's decision on the facts, in which you reflect on the impact of falling

asleep whilst on duty. He submitted that you have learnt your lesson, are a safe practitioner and have demonstrated what steps you would take in the future if you were not fit to work or if while at work you felt tired or unwell. He stated that you have worked as a registered nurse in the UK in various settings since 2004 with no other concerns raised about your practice. He submitted that you have fully cooperated with the NMC throughout the investigation.

Dr Akinoshun submitted that you have remediated the concerns and that you do not present a risk to the public. He submitted that you have shown insight and would not repeat the kind of conduct found proved. He submitted that you have accepted the panel's findings in relation to the charges you denied.

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, *Mallon v General Medical Council* [2007] CSIH 17, *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (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 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. Specifically:

> ***'8 Work co-operatively***
> *To achieve this, you must:*
> *8.2 maintain effective communication with colleagues*
> *8.5 work with colleagues to preserve the safety of those receiving care*

8.6 share information to identify and reduce risk

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:

14.2 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

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'

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 falling asleep whilst on duty and conducting one to one, level three observations on a vulnerable patient was serious, especially due to the risk of harm which materialised in this case. The panel further considered that acting dishonestly and not providing an accurate handover was serious. Your conduct resulted in harm to Patient A and could have resulted in further harm had you not woken up and had another colleague not discovered that Patient A had ligatured. Your conduct also had a negative impact on your colleagues as you failed to be open and candid with them about what had happened and to ensure that correct information was shared with them so they could properly identify and reduce the risks to Patient A.

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

The panel finds that all four limbs of *Grant* are engaged. The panel finds that Patient A was put at unwarranted risk of harm and suffered physical harm as a result of you falling asleep. In addition to the harm caused to Patient A from the ligature, they had to be restrained and sent to hospital the next day to have the NG tube reinserted under general anaesthetic. The panel also finds that Patient A was put at further risk of harm as a result of you failing to inform Colleague 1 that you fell asleep whilst observing Patient A. Your misconduct breached the fundamental tenets of the nursing profession, particularly with regard to acting with honesty and integrity. Your misconduct also brought the reputation of the nursing profession into disrepute.

The panel first considered your misconduct in falling asleep. It recognised that this was a one off event in an otherwise unblemished nursing career spanning 14 years. The panel took into account the evidence from Colleague 1 and Ms 2 with whom you had worked on the Unit and also the testimonials you had provided. The panel also took into account your two reflective statements and your oral evidence in which you expressed your remorse and regret for falling asleep whilst observing Patient A.

The panel accepted that your behaviour was not deliberate, that you had good insight into how it had happened and what action you would take in the future to prevent a similar

situation arising. The panel accepted that you understood the seriousness of what had happened and the impact this had on Patient A and your colleagues. In light of all the information provided to it, the panel was satisfied that you presented a low risk of repeating the misconduct of falling asleep.

The panel next considered your misconduct and dishonesty in failing to provide Colleague 1 with an accurate handover. The panel considered that you have not yet fully accepted that you acted dishonestly and found that you have limited insight into this aspect of your misconduct. The panel noted that in your updated reflective statement you state:

> *'The Panel`s verdict earlier today has given me further opportunity to reflect upon my actions and how the members of the public might have perceived my handover to colleague 1 as being dishonest.'*

The panel was satisfied that the misconduct in this case is capable of being addressed. The panel considered that your dishonesty in failing to provide an accurate handover to Colleague 1 was an isolated incident and not prolonged. You admitted in your original reflective statement to the Agency, a few days after the incident, that you had fallen asleep.

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 reflective statement and references you provided. The panel noted that the references relate mainly to your current practice and state that they have not had any issues with you falling asleep on duty. The panel noted that you have worked as a registered nurse since the incident with no further concerns being raised about your practice.

The panel is of the view that there is a risk of repetition of you acting dishonestly if an incident were to occur whilst at work. The panel considered that whilst your reflective statement talks about dishonesty, the comments are not specific to the charges and are general comments about the importance of acting honestly, for example you state:

‘Honesty and trustworthiness are the bedrock of our nursing profession. Honesty and good character are absolutely paramount to inspire public confidence and trust in our profession.’

The panel considered that you have shown limited insight and have not demonstrated how you have remediated the dishonesty aspect of your misconduct. Although this was a one-off incident, the panel was not satisfied that you have demonstrated how you would act differently if you were involved in an incident at work again. The panel therefore considered that there was a risk of repetition of you acting in a dishonest way in the future.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection in relation to not providing an accurate handover and acting dishonestly.

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

The panel 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 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.

Decision and reasons on interim order

The hearing was listed as a split hearing and adjourned on 7 January 2022 following the panel giving its decision on impairment.

Under Rule 32(5) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules), the panel considered whether it was necessary to impose an interim order.

In reaching its decision, the panel considered the documentation before it, together with submissions by Ms Stewart on behalf of the NMC and submissions from Dr Akinoshun. The panel accepted the advice of the legal assessor and took account of the guidance issued by the NMC to panels considering interim orders and the appropriate test as set out at Article 31 of the 'Nursing and Midwifery Order 2001' (the Order). It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or is in your own interests.

Ms Stewart made an application to impose an interim suspension order. She submitted that no other sanction would mitigate the risks found. She submitted it would not be possible to formulate a conditions of practice order that would address the dishonesty in this case. She submitted that due to the panel's findings, it is in the public interest for an interim order to be imposed.

Dr Akinoshun stated that the case was referred to the NMC in 2018 and there has been no previous interim order applications. He stated that you have been working since 2004 with no other concerns, including after the incident. He submitted that the risk level has not increased since the case was referred to the NMC. He referred the panel to the references provided by you which he submitted show you have practised safely since the incident. He submitted that an interim order is not necessary to protect the public, and that it is not appropriate and would be unfair to restrict your practice at this stage before the panel decide which sanction should be imposed.

The panel considered that you have not previously been subject to an interim order and there have been no further concerns raised about your practice since the incident. The panel did not agree with Dr Akinoshun's submission that nothing has changed since the referral. This panel has found that you acted dishonestly. It has carefully considered your

insight and made a finding of impairment on the grounds of both public protection and public interest. The panel has found that there is a risk that you may act dishonestly in the future.

The panel considered that imposing an interim order would have an adverse impact on you, and was sympathetic to this, but determined that an order is necessary to protect the public and is otherwise in the public interest in light of its finding of impairment.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case. The panel determined that it would not be possible to formulate conditions of practice at this stage that would address the dishonesty identified due to your limited insight. The panel therefore imposed an interim suspension order for a period of three months to protect the public and maintain the public interest in the interim period until this substantive hearing concludes.

The hearing is scheduled to resume on 31 January 2022.

This will be confirmed to you in writing.

Sanction

The hearing resumed as scheduled on 31 January 2022.

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

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 Stewart informed the panel that in the Notice of Hearing, dated 29 November 2021, the NMC had advised you that it would seek the imposition of a suspension order for a period of 12 months if it found your fitness to practise currently impaired.

Ms Stewart submitted that you should be suspended until you demonstrate full insight. She submitted that it is clear you have not accepted that you acted dishonestly, and there is a need for you to reflect on the way you dealt with the handover to Colleague 1. She submitted that taking no action or imposing a caution order was not appropriate due to the seriousness of the misconduct, as your dishonesty places your misconduct at the higher end of the spectrum of seriousness.

Ms Stewart submitted that it is not possible to formulate a workable conditions of practice order that would protect the public. She submitted that dishonesty cannot be addressed through training or supervision, and that conditions of practice were not proportionate.

Ms Stewart referred the panel to the NMC's guidance on 'Considering sanctions for serious cases'. She submitted that dishonesty is always serious and is hard to put right. She submitted that Patient A was caused harm due to you falling asleep, but had you been honest and candid about the incident, there may not have been a need for regulatory intervention. She submitted that you deliberately breached the duty of candour in relation to your nursing practice and that your reflective statements lack insight. She invited the panel to impose a suspension order for 12 months with a review.

Dr Akinoshun stated that the panel should first consider the least serious sanction and the sanction imposed should be the least restrictive necessary to protect the public. He submitted that there is a public interest in an experienced nurse being permitted to practise. He submitted that you have provided reflective statements that demonstrate insight, have taken action to address your failings and have kept up to date with your

areas of practice. He reminded the panel that you made an early admission to charge 1 and have accepted the panel's findings in relation to charges 2b and 3.

Dr Akinoshun reminded the panel of the personal mitigation at the time of the incident. He submitted that you have worked since the incident with no further regulatory concerns. He submitted that the mitigating factors include your engagement with the NMC, a lack of previous concerns, no previous findings of misconduct and no repetition since the incident. He outlined your financial situation and responsibilities.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Your dishonesty placed a vulnerable patient at further risk of harm
- You have demonstrated limited insight into your dishonesty
- You were the nurse in charge of the shift and were in a position of responsibility

The panel also took into account the following mitigating features:

- There is nothing to suggest you have repeated the misconduct and it appears that the dishonesty was a one-off incident
- You made an early admission to charge 1

The panel noted Dr Akinoshun's submission in relation to your personal circumstances at the time of the incident and whilst the panel accepted that this had an impact on you falling asleep, it determined that it did not impact your dishonest behaviour.

The panel further considered the NMC's guidance on cases involving dishonesty. The panel determined that the following factors were present that demonstrated the seriousness of your dishonesty:

- You deliberately breached the professional duty of candour by covering up when things went wrong at work.
- Your dishonesty had the potential to cause further harm to a vulnerable patient (e.g. more restrictive measures could have been placed on Patient A).

However, the panel also noted that this was a one-off incident and your dishonesty was not premeditated, systematic or longstanding.

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

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

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

- *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; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that the misconduct identified in this case was not something that can be addressed through retraining as the concerns relate to dishonesty and not your clinical practice. The panel considered your limited insight into the dishonesty and determined that there are no practical or workable conditions that could be formulated that would address your dishonesty.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour…*

The panel determined that a suspension order would ensure that the public was sufficiently protected. The panel considered that the misconduct was a single instance and there is no evidence of deep-seated personality concerns or attitudinal issues. The panel noted that there is nothing to suggest that you have repeated the misconduct since the incident. However, the panel considered that you have only shown limited insight into your dishonesty and determined that a period of suspension is appropriate and proportionate to permit you time to reflect on your actions and further develop your insight.

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

The panel went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order is the appropriate and proportionate sanction.

The panel noted the financial hardship such an order will cause you, and noted your financial situation as outlined by Dr Akinoshun. However, this is outweighed by the need to protect the public and uphold the public interest in this case.

The panel determined that a suspension order for a period of six months was appropriate and proportionate in this case to mark the seriousness of the misconduct and to allow you time to reflect and develop your insight.

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

Any future panel reviewing this case would be assisted by:

- A further reflective statement outlining your understanding of your dishonesty. This should include the impact of your dishonesty on your colleagues, patients, the nursing profession and the public. In addition, you may wish to include examples of when you have encountered situations (particularly in a work environment), where you have been candid and acted with honesty and integrity.
- Your continued engagement with the NMC and attendance at the review hearing.
- Testimonials from any employment, whether paid or unpaid, which address your character.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Stewart. She invited the panel to impose an interim suspension order for a period of 18 months to cover any appeal period. She stated this was necessary due to the panel's findings.

Dr Akinoshun stated that he was indifferent as to the application made by Ms Stewart.

Decision and reasons on interim order

The panel is 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, including dishonesty, and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.