Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 23 May – Thursday 26 May
Monday 30 May – Wednesday 1 June 2022
Thursday 9 June – Tuesday 14 June 2022

Virtual Hearing

Name of registrant:	Abeni Olutayo Odebode
NMC PIN:	17G0853E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – July 2018
Area of registered address:	Berkshire
Type of case:	Misconduct/Lack of competence
Panel members:	Janet Fisher (Chair, Lay member) Claire Rashid (Registrant member) Alexandra Hawkins-Drew (Registrant member)
Legal Assessor:	John Bromley-Davenport QC
Hearing Coordinator:	Teige Gardner [23-26, 30-31 May – 1 June 2022], [9 June 2022], [13-14 June 2022] Vicky Green [10 June 2022]
Nursing and Midwifery Council:	Represented by Louis Maskell, Case Presenter
Mrs Odebode:	Not present and unrepresented
Facts found proved:	1a, 1a (i), 1a (ii), 1a (iii), 1a (iv), 1a (v), 1a (vi), 1b, 1c, 1d, 1e, 1g, 2a, 2b, 2c, 2d, 2e, 2f, 3, 4, 5, 6, 7, 8a, 8c, 8d, 8e, 8f, 8g, 8h, 9a, 9b, 9c, 10a, 10b, 11a, 11b, 12, 13, 14, 15, 17, 18, 20, 21
Facts not proved:	1f, 8b, 16a, 16b, 19a, 19b, 19c
Fitness to practise:	Impaired

Sanction: Suspension Order, with a review (12 months)

Interim order: Interim Suspension Order (12 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Odebode was not in attendance and that the Notice of Hearing letter had been sent to Mrs Odebode's registered email address on 4 April 2022.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Odebode's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

The panel accepted the advice of the legal assessor.

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

Decision and reasons on proceeding in the absence of Mrs Odebode

The panel next considered whether it should proceed in the absence of Mrs Odebode. It had regard to Rule 21 and heard the submissions of Mr Maskell who invited the panel to continue in the absence of Mrs Odebode. He submitted that Mrs Odebode had voluntarily absented herself. He submitted that adjourning proceedings today would not guarantee

Mrs Odebode's attendance at a later date. He submitted that it was fair to deal with this case today, as it would be unfair to the NMC and their witnesses if this case is adjourned. He submitted that there is a strong public interest in the expeditious disposal of the case.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mrs Odebode;
- Mrs Odebode has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence. In her representations, Mrs Odebode states: *"I have taken the decision not to attend the hearing nor will I be represented in my absence. I confirm that I understand and agree that the hearing can proceed in my absence";*
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Ten witnesses are due to attend these proceedings to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in late 2018;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Odebode in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Although the panel noted that there are a number of admissions in Mrs Odebode's defence bundle, the panel will consider the weight of these when deciding upon the individual charges. Furthermore, the limited disadvantage is the consequence of Mrs Odebode's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented.

The disadvantage to Mrs Odebode will also be mitigated by reason of the lengthy defence bundle she has provided. This sets out her case in considerable detail and also contains references from her current employers and other documents, all of which the panel will take into account in making its decisions.

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

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

At the outset of the hearing, Mr Maskell made a request that this case be held partly in private on the basis that proper exploration of Mrs Odebode's case involves references to health. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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 references to health as and when such issues are raised.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Maskell under Rule 31 to allow the written statement of Witness 11 into evidence. Witness 11 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, he was unable to attend today due to him sadly passing away on 13 February 2022. Mr Maskell referred the panel to the death certificate of Witness 11. He submitted that it is relevant and fair to admit Witness 11's written witness statement into evidence. He informed the panel that Witness 11's evidence is sole and decisive for one of the charges. However, he submitted that his evidence is linked with the evidence of Witness 6, which supports Witness 11's written statement.

In the preparation of this hearing, the NMC had indicated to Mrs Odebode in the Case Management Form (CMF), dated 24 January 2022, that it was the NMC's intention for Witness 11 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 11, Mrs Odebode made the decision not to attend this hearing. On this basis Mr Maskell advanced the argument that there was no lack of fairness to Mrs Odebode in allowing Witness 11's written statement into evidence, as she herself has provided a hearsay written witness statement for today's hearing that has already been admitted to evidence. He invited the panel to admit Witness 11's written witness statement into evidence.

The panel accepted the advice of the legal assessor.

The panel gave the application in regard to Witness 11 serious consideration. The panel noted that Witness 11's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by him.

The panel considered that as Mrs Odebode had been provided with a copy of Witness 11's statement and, as the panel had already determined that Mrs Odebode had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel was of the view that the charge Witness 11's statement is related to is serious. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 11 and the opportunity of questioning and probing that testimony. The panel also noted that Witness 11 had nothing to gain from fabricating his witness statement. Furthermore, the panel noted that Mrs Odebode has partially admitted to part of charge 16, which Witness 11's evidence is also relevant.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 11 but would give it what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Maskell, on behalf of the NMC, to amend the wording of charge 11.

The proposed amendment was to charge 11, as Mr Maskell submitted there was an error which made the charge factually inaccurate. He submitted that charge 11 would be clearer

and more accurately reflect the evidence if *Scope Room* was changed to *Recovery Room*. He submitted that the facts of this charge are denied by Mrs Odebode, but nothing turns on the location, so there would be no unfairness to her if this charge is amended to reflect the evidence.

"That you as a registered nurse;…

1. *Were unable to manage and/or prioritise time when recovering patients in the ~~Scope~~ Recovery Room;*
    (a) On the 11 July 2019
    (b) On other dates unknown…"

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

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

Following the closing of the NMC's case, the panel noticed that the date in charge 7 was incorrect. The panel used its power to amend charge 7 to more accurately reflect the factual evidence.

"That you as a registered nurse;…

7. *On the ~~16~~ 15 October 2018 were unaware and/or unable to understand NEWS system..."*

The panel was satisfied that there would be no prejudice to Mrs Odebode and no injustice would be caused to either party by the proposed amendment being allowed. The facts of this charge are denied by Mrs Odebode, but nothing turns on the date, so there would be no unfairness to her if this charge is amended to reflect the evidence. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge

"That you as a registered nurse;

Between 2 September 2018 and 1 November 2018, whilst working on Eashing Ward, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you;

1. *Between 20 September 2018 and 17 October 2018 failed to manage your time in order to:*
   (a) Complete learning and/or training in specific areas;
      (i) Tissue Viability Nurse online training
      (ii) Medicines Theory Workbook
      (iii) Practical Medication Assessment
      (iv) VitalPac training
      (v) Blood glucose charts
      (vi) NEWS training
   (b) Deal with patients whilst working on the bay
   (c) Complete patient notes prior to leaving work
   (d) Complete handovers prior to leaving work
   (e) Adequately write up patient care plans
   (f) Carry out tasks in a timely manner
   (g) Complete drug rounds in a timely manner

2. *Between the 1 October 2018 and 4 October 2018 had to be prompted:*

(a) To check patients name bands

(b) To check the allergies for each patient

(c) To complete hand hygiene between each patient

(d) To check the drug chart prior to administering drugs to a patient

(e) To check the prescription for a patient

(f) That medication had already been provided to a patient

3. *On the 2 October 2018 were unable to successfully complete a medication administration assessment.*

4. *On the 16 October 2018 incorrectly placed a blood pressure cuff on a patient.*

5. *On the 15 October 2018 were unable to complete relevant patient documentation whilst monitoring blood glucose levels.*

6. *On the 15 October 2018 were unable to understand abbreviations contained within patient notes.*

7. *On the 15 October 2018 were unaware and/or unable to understand NEWS system.*

Between 2 December 2018 and 25 July 2019, whilst working in the Endoscopy Unit, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you;

8. *Between the 28 May 2019 and the 12 July 2019 were unable to consistently go through the World Health Organisation ("WHO") checklist by;*

(a) Failing to ensure that patient notes match the WHO form

(b) Failing to show the consent form to the patient

(c) Failing to clarify the procedure with the patient

(d) Failing to check whether the patient had any questions about the procedure

(e) Failing to label biopsies taken during the procedure

(f) Failing to ensure drug charts had been completed adequately

(g) Failing to check a patient's name against their wrist band

(h) Failing to document the number of specimens taken

9. *Were seen to handle and/or handover biopsy forceps incorrectly;*

   (a) On or around the 18 March 2019.

   (b) On the 11 July 2019.

   (c) On other unknown dates.

10. *Were unable to recognise and/or state the location from which a biopsy had been taken from a patient;*

    (a) On the 11 July 2019

    (b) On other unknown dates

11. *Were unable to manage and/or prioritise time when recovering patients in the Recovery Room;*

    (a) On the 11 July 2019

    (b) On other dates unknown

12. *On the 11 July 2019 failed to set up suction equipment to manage a patient's airway correctly.*

13. *On an unknown date and/or dates were unable to demonstrate competence to manage a patient's airway in that you needed prompting when suction was required.*

14. *On an unknown date and/or dates were unable to complete complex discharges.*

15. *On an unknown date and/or dates were unable to cannulate unsupervised despite being signed off as competent in May 2019.*

16. *On 13 June 2019:*
    (a) Were unable to administer an enema to Patient A correctly;
    (b) Spilled or caused to spill liquid on Patient A

17. *On the 22 July 2019 incorrectly selected Pethidine to be administered to a patient when it should have been Midazolam.*

18. *In the week commencing the 25 February 2019, incorrectly removed the line containing the blood from the pump when not intravenous trained.*

And in light of charges 1 – 18 above your fitness to practise is impaired by reason of your lack of competence.

That you a registered nurse;

19. *On 13 June 2019 in relation to Patient A:*
    (a) Said words to the effect of "what are you doing?"
    (b) Shouted;
    (c) Behaved aggressively and/or rudely.

20. *On the 10 July 2019 fell asleep whilst monitoring patient C.*

21. *On the 17 July 2019 fell asleep whilst monitoring patient B.*

And in light of charges 19 to 21 above your fitness to practise is impaired by reason of your misconduct."

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Maskell on behalf of the NMC and the written defence bundle from Mrs Odebode.

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

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

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

- Witness 1: Senior Sister on Eashing Ward (the Ward) at the Royal Surrey County Hospital NHS Foundation Trust (the Hospital)
- Witness 2: Junior Sister on the Ward
- Witness 3: Practice Development Sister at the Hospital with responsibilities for the Ward
- Witness 4: Sister on the Endoscopy Unit (the Unit)
- Witness 5: Matron on the Unit
- Witness 6: Senior Sister on the Unit
- Witness 7: Sister on the Unit

- Witness 8: Charge Nurse on the Unit
- Witness 9: Sister on the Unit
- Witness 10: Sister on the Unit

The panel also received a written witness statement from Witness 11/Patient A which, as seen above, it admitted into evidence.

- Witness 11/Patient A Patient undergoing treatment at the Unit

Furthermore, the panel had regard to the written defence bundle from Mrs Odebode.

Background

The NMC received a referral from Royal Surrey County Hospital NHS Foundation Trust (the Hospital) on 13 August 2019 regarding Mrs Odebode. She was employed as a newly qualified band 5 staff nurse from September 2018, initially on Eashing Ward (a long stay elderly care ward) and then on the Endoscopy Unit. The referral relates to concerns with Mrs Odebode's conduct and competence. The concerns are wide ranging and relate to basic nursing duties including her:

- Ability to carry out various nursing tasks;
- Time management and prioritisation;
- Poor record keeping;
- Lack of ability to consistently and systematically complete required tasks without direct instruction;
- And competence in giving medication advice and medication administration.

Mrs Odebode's probationary period of six months at the Hospital was extended by three months and the Hospital arranged meetings to assess her progress. It was decided on 25 July 2019, after eight months of probation, that Mrs Odebode was unable to achieve the targets agreed with her manager and she was subsequently dismissed.

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 Mrs Odebode.

The panel had sight of Mrs Odebode's defence bundle and, in respect of the context of when the charges arose, the following:

> *'I did feel in my time on both Eashing Ward and the Endoscopy Unit that the way I was assessed was hugely subjective and that I was not given one document setting clear SMART objectives on all concerns that were later raised about my performance. This meant I was not able to clearly address the concerns. Over time I very much began to feel bullied and that I had lost a lot of confidence.'*

Before making its determination on the charges, the panel had regard to the above and considered the context in which Mrs Odebode was working as a newly qualified staff nurse. It was of the view that she was working in a very supportive and helpful environment. The panel heard oral evidence from a number of the witnesses around the structured induction process and the enhanced support provided for Mrs Odebode within the Ward and the Unit. The panel was of the view that all of her mentors wanted Mrs Odebode to succeed and made extensive efforts to facilitate her learning and development.

Charges that arose on Eashing Ward

The panel considered the stem of charges 1-7 and gave careful consideration to the standards of knowledge, skill and judgement that could be fairly expected of a band 5 nurse to practise without supervision.

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

Charge 1a (i)

"That you as a registered nurse:

1. *Between 20 September 2018 and 17 October 2018 failed to manage your time in order to:*
   a) *Complete learning and/or training in specific areas;*
      i. *Tissue Viability Nurse online training"*

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, in particular the Hospital's training policy and Mrs Odebode's action plan. The panel first considered whether Mrs Odebode had a duty to complete learning and/or training in tissue viability within the time expected by the Hospital. The panel was of the view that staff working on a care of the elderly ward had a responsibility to be up to date with tissue viability training. The panel heard from Witness 1 and Witness 2 that the tissue viability online training was an initiative to support safe practice within the Hospital. Therefore, the panel was satisfied that Mrs Odebode did have a duty to ensure that she completed her learning and training in tissue viability within the time set by the Hospital.

The panel took into consideration Mrs Odebode's explanation for this charge. The panel noted that she said she could not recall whether she completed this training between the dates specified. The panel noted that Mrs Odebode's action plans, dated 11 October 2018 and 15-20 October 2018, specifically state that she was still required to complete the

learning and training in tissue viability, and pass the assessment. The panel noted the oral evidence of Witness 1 and Witness 2 that the tissue viability learning and subsequent test is usually completed within an hour. The panel noted the report of 21 September 2018 outlined that it took Mrs Odebode three hours to complete and finish the training and she subsequently failed the assessment. In light of this, the panel determined that, on the balance of probabilities, this charge is found proved.

Charge 1a (ii)

"…

ii. Medicines Theory Workbook"

This charge is found proved.

In reaching this decision, the panel took into account Mrs Odebode's admission that she did not complete this workbook whilst working on the Ward. The panel considered the Hospital's medicines management policy and whether Mrs Odebode had a duty to complete the Medicines Theory Workbook within the set timescales. The panel noted and accepted the evidence of Witness 2 that completing the Medicines Theory Workbook was a clear expectation and that time was set aside for Mrs Odebode to complete it.

Further, the panel noted that it took Mrs Odebode an extended period of time to finish the Medicines Theory Workbook, she was supernumerary for two weeks and was given a full day and support to work on it. In addition, the panel noted that Mrs Odebode admitted to failing to complete the Medicines Theory Workbook and not managing her time well to do so. The panel determined that this charge is found proved.

Charge 1a (iii)

"…

iii. Practical Medication Assessment"

This charge is found proved.

In reaching this decision, the panel took into account Mrs Odebode's admission that she did not complete this whilst working on the Ward. As seen above, the panel found that Mrs Odebode had a duty to complete the Practical Medication Assessment within the time scale set out. The panel noted and accepted the evidence of Witness 2 that *'During the Registrants first 2 weeks as supernumerary the Registrant would have been asked to complete these workbooks and then do a supervised drug round'*.

The panel was of the view that Mrs Odebode was given adequate time to complete the learning and the Practical Medication Assessment. The panel noted that Mrs Odebode admitted to failing to complete the Practical Medication Assessment within the timescale set for her, failing it on 2 October 2018. The panel was of the view that the time scale for Mrs Odebode to complete the assessment was realistic, and not successfully completing it indicates poor time management. The panel had regard to Mrs Odebode's defence bundle which contained evidence that she did not pass this assessment until 6 March 2019. Therefore, the panel determined that this charge is found proved.

Charge 1a (iv)

"…

iv. VitalPac training"

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Witnesses 1, 2 and 3 and Mrs Odebode's written statement. The panel noted that, in their oral evidence, Witnesses 1, 2 and 3 informed the panel that Mrs Odebode was told that she was required to complete VitalPac training, however she failed to do so within the time scale expected of her, and that after three attempts at training the VitalPac trainer was still not confident

Mrs Odebode understood the system so was unable to provide her with a PIN number to access it. Furthermore, the panel noted the email to Witness 1 from Witness 2 which enclosed a statement written on 21 September 2018 regarding Mrs Odebode's progress:

> *'Abeni did not tell me that [VitalPac Nurse] had to stop her training because she was dozing off. The [VitalPac Nurse] did say to inform me or [Sister] but she didn't.'*

The panel was of the view that, in relation to this charge, the oral evidence from Witnesses 1, 2 and 3 was consistent, reliable and credible. The panel noted Mrs Odebode recalls completing this training whilst she was on the Ward. The panel also noted that the VitalPac training was still listed in Mrs Odebode's action plan for the week commencing 15 October 2018.

The panel weighed the evidence, and was of the view that Mrs Odebode was given a reasonable amount of time to complete the VitalPac training, however she failed to manage her time appropriately in order to complete it within the timescale expected of her. Therefore, the panel was of the view that, on the balance of probabilities, this charge is found proved.

Charge 1a (v)

"…

v. Blood glucose charts"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1 and 3, and Mrs Odebode's admission. The panel noted that both Witnesses 1 and 3 clearly stated that completing learning and/or training in blood glucose charts was required of Mrs Odebode. The panel was of the view that Witnesses 1 and 3, in regard to this charge, were credible, consistent and reliable.

The panel noted that Mrs Odebode admitted to not managing her time correctly in order to complete learning and training in blood glucose charts. The panel rejected Mrs Odebode's explanation that she had already completed blood glucose charts as a trainee nurse, this was not sufficient, she was under a duty to complete her learning and training on the Ward. The panel determined that, on the balance of probabilities, this charge is found proved.

Charge 1a (vi)

"…

vi. NEWS training"

This charge is found proved.

In reaching this decision, the panel took into account Mrs Odebode's admission that she had not completed learning and/or training on the Ward, but that she had covered this area during her nurse training. The panel noted that there was no specific training course in respect of NEWS, it was contained within the VitalPac training and then Mrs Odebode was given ongoing support by her mentors. Witness 3 stated that when she worked with Mrs Odebode on 15 October 2018:

> *'I showed her how to use the VitalPac Ipad and I explained what the National Early Warning Score (NEWS) was, explaining how it is used to monitor deterioration in patients. The Registrant was unfamiliar with the NEWS. The Registrant said she did not know what the parameters were for the NEWS or where she could find this information…*
>
> *… The NEWS is a nationally used patient deteriorating monitoring assessment tool. I expect newly qualified nurses who have trained in the UK to have an understanding of this tool. I was shocked the registrant did not have this level of knowledge.'*

The panel noted that she said she was unaware of what NEWS. Mrs Odebode admitted to not managing her time well enough to complete the learning and/or training in NEWS. Therefore, this charge is found proved.

Charge 1b)

"(b) Deal with patients whilst working on the bay"

This charge is found proved.

In reaching this decision, the panel took into account the context of Mrs Odebode's working environment and Mrs Odebode's written statement. The panel was of the view that the Hospital was well-staffed. It noted that Witness 2 states that there were always *"six nurses and four Health Care Assistants (HCAs) on the Unit"* and sometimes there were even extra HCAs in particular circumstances, for up to 30 patients. Further, the panel noted that at the time this concern was alleged, Mrs Odebode was supernumerary and was receiving extensive support, from both clinical mentors and the practice development nurse, and was not required to complete drug rounds. The panel noted that Witness 1 and Witness 3 stated that Mrs Odebode was polite, friendly and respectful to patients. However, she did not manage her time well and needed directing by other staff members to undertake basic care duties, such as feeding, bathing and monitoring blood glucose levels. As an example, on 4 October 2018 Witness 1 recorded in an email that *'she concentrated on documentation and failed to respond to the call bells and other patient immediate needs. I had to prompt her to check her patient in the cubicle as one of them need settling and making sure the syringe driver is working.'*

The panel noted that Mrs Odebode does not accept this charge. However, the panel was of the view that, in light of the above, Mrs Odebode was sufficiently supported in order to deal with patients in the bay in a timely manner. The panel was of the view that, it is not unreasonable to expect a newly qualified nurse to be able to manage their own workload

after undertaking a short settling in period in a new clinical environment. The panel found that Mrs Odebode, even though she was still supernumerary, was unable to do this which indicated that she was not managing her time well enough to deal with patients whilst working on the bay. Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 1c)

" (c) Complete patient notes prior to leaving work"

This charge is found proved.

The panel noted that Mrs Odebode denied this charge. In reaching this decision, the panel took into account the evidence of Witness 2. The panel first considered if Mrs Odebode had a duty to complete patient notes before leaving work. The panel was of the view that she did, in coming to this decision it noted that Witness 2 stated in her oral evidence that there was an expectation for Mrs Odebode to complete her notes before she left the Hospital. In addition, the panel noted the safety issues that could be caused if a nurse did not document the full care provided during a shift, as the oncoming staff would be unaware of any changes in the patients' clinical status or needs. Therefore, the panel was satisfied that Mrs Odebode had a duty to complete patient notes before leaving work.

The panel also noted that, in Witness 2's witness statement, she stated that she saw Mrs Odebode *'rushing to leave the Unit'* on one occasion before the end of her shift *'and the patient's notes had not been completed correctly'.* In her oral evidence, Witness 2 also detailed that Mrs Odebode took charge of an admission to the Ward at 17:00, and when Witness 2 checked the clinical documents as Mrs Odebode was leaving the Ward at 19:20, the admission records were found to be incomplete and lacking vital clinical information. The panel was of the view that, with regard to this charge, Witness 2's

evidence was credible and reliable. Therefore, the panel determined that on the balance of probabilities this charge is proved.

Charge 1d)

"(d) Complete handovers prior to leaving work"

This charge is found proved.

The panel noted that Mrs Odebode denied this charge. In reaching this decision, the panel took into account the evidence of Witness 2, and Mrs Odeode's explanation. The panel first considered whether Mrs Odebode had a responsibility to complete handovers before leaving work. The panel was of the view that the Hospital's policy was very clear that she did, also it noted that Witness 2 expressed the importance of Mrs Odebode completing handovers before she finished her shift. The panel noted the safety issues that could arise if a nurse did not handover the care they had provided to the oncoming staff. This would include up to date details of the patients' clinical status and needs at the end of each shift. Therefore, the panel was satisfied that Mrs Odebode was required to complete handovers prior to leaving work.

The panel noted that Witness 2 told the panel in both her oral and written evidence that, on 16 October 2018, Mrs Odebode failed to complete her handover before finishing work, which then Witness 2 had to complete on her behalf. The panel noted that this contradicts Mrs Odebode's explanation of events, being that once a senior colleague had offered to complete her handover, as this was clearly a different occasion. The panel weighed the evidence before it, and was of the view that Witness 2's evidence was reliable and cogent. Therefore, the panel found this charge proved on the balance of probabilities.

Charge 1e

"(e) Adequately write up patient care plans"

This charge is found proved.

In reaching this decision, the panel took into account Mrs Odebode's explanation and the evidence of Witness 1 and Witness 2. The panel noted that Mrs Odebode claimed she was not trained in writing up care plans, and further she always wrote adequate notes. Witness 1, when asked by the panel whether the Registrant had been trained to write patient care plans, was clear that a student nurse would cover this during their nurse training and that in any event she had sat with the Registrant *"more than a couple of times"* to explain what she wanted from her notes and what was needed. The panel noted that Witness 2 stated in her oral evidence that she did not always find Miss Odebode's notes to be adequate. The panel noted that Witness 2 said that Mrs Odebode's patient notes and care plans were *"not as descriptive and patient centred as they should be"* and always looked like they were *"written in a hurry"* and Mrs Odebode said that she had *"little time"* to write detailed notes. Witness 2 said that this should not have been the case, as Mrs Odebode was supernumerary and not able to do drug rounds, and therefore had plenty of time to write detailed notes.

In light of the above, the panel was of the view that Witness 1 and 2's evidence outweighed Mrs Odebode's evidence in regard to this charge. The panel concluded that Mrs Odebode had sufficient time to write detailed care plans, but failed to manage her time efficiently to do so. The panel determined that this charge is therefore found proved.

Charge 1f

"(f) Carry out tasks in a timely manner"

This charge is found not proved.

In reaching this decision, the panel took into account Mrs Odebode's written statement. The panel noted that, in her written statement, Mrs Odebode stated that:

"Without specific examples of which tasks the NMC is referring to in this charge including an explanation of how long I took to complete a task(s) and how long I should have taken, I feel I cannot either admit or deny this."

The panel accepted Mrs Odebode's position on this charge. It was of the view that this charge was too vague, and did not properly outline what tasks Mrs Odebode was meant to complete in order for her to respond adequately to this charge. Therefore, the panel found this charge not proved.

Charge 1g

"(g) Complete drug rounds in a timely manner"

This charge is found proved.

In reaching this decision, the panel took into account evidence from Witness 1, Witness 2 and Witness 3 and Mrs Odebode's explanation of events. The panel firstly noted that Mrs Odebode was unable to complete drug rounds consistently and independently, as she had failed to pass the necessary assessment required to do so. The panel noted that Witness 3 stated that drug rounds should take roughly 10 minutes per patient, whereas Mrs Odebode took nearly two hours to complete a supervised medication round for six patients. The panel accepted this evidence.

The panel noted that Mrs Odebode, in her written statement, said:

"Without specific examples of which drug rounds the NMC is referring to in this charge including how long I took to complete a drug round(s) and how long I should have taken, I feel I cannot either admit or deny this."

The panel rejected Mrs Odebode's position on this charge. The panel heard oral evidence from Witness 2 as to why the drug rounds undertaken by Mrs Odebode were unable to be completed in a timely manner, Witness 2 recalled that Mrs Odebode required support and direction to undertake drug rounds due to gaps in her knowledge around medication. She also recalled that Mrs Odebode was unable to read the drug chart without support and described Mrs Odebode's practice with regard to drug rounds as *"unsafe"*.

In light of the above, the panel was of the view that Mrs Odebode did not manage her time effectively in order to complete drug rounds in a timely manner. Therefore, the panel finds this charge proved on the balance of probabilities.

Charge 2

"…

2. *Between the 1 October 2018 and 4 October 2018 had to be prompted:*
   (a) To check patients name bands
   (b) To check the allergies for each patient
   (c) To complete hand hygiene between each patient
   (d) To check the drug chart prior to administering drugs to a patient
   (e) To check the prescription for a patient
   (f) That medication had already been provided to a patient"

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Witness 3, a report dated 4 October 2018 from another registered nurse (Nurse 1) in the Hospital who supervised Mrs Odebode on 1 October 2018, and Mrs Odebode's written statement. The panel first considered what weight to give to the evidence from Nurse 1, as she did not attend the proceedings to give live evidence. The panel was of the view that Nurse 1 had no reason to fabricate evidence and understood the importance of her statement, and the implications it might have for Mrs Odebode. The panel was of the view that her report was

clear, specific and detailed. In addition, the panel noted that this report was completed on 4 October 2018, three days after she did the drug round with Mrs Odebode. The panel was of the view that this increases the reliability of the statement. Therefore, the panel decided it could attach significant weight to this report.

In Nurse 1's statement, it states that she:

> *'Needed to prompt her in checking the name bands, allergies of each patient and hand hygiene in between patients as she tend to forget it after just a few minutes of telling her especially the hand hygiene and checking of name bands...*
>
> *I asked her to check the drug chart again as she was about to give another dose despite the clear instruction on the charge…*
>
> *I prompted her to check the prescription carefully, and only then she realised that she had to administer 2 tablets…*
>
> *Abeni did not realise that we had already given her medicine at lunch time, had I not told her she would have administered the medication again'*

The panel also noted that, in a statement dated 2 October 2018, Witness 3 states:

> *'On commencing the morning drug round Abeni worked with the staff nurse with the first two patients. I observed the staff nurse and Abeni discussing the dose for one of the patients, Abeni said "I think I would give 3 tablets" on hearing this debate I stepped in and encouraged Abeni to use a calculator and informed her to always be sure of what she is about to be administering not to just "think" the dose to be correct. Following this I took over from the drug round to administer the due medication to the next 6 patients with Abeni. I asked Abeni if she felt confident enough to be assessed or whether she would like to do the drug round together as a training and teaching session rather than an assessment. Abeni informed me she*

felt more than ready to be assessed and "wanted to get on with it". Abeni informed me she felt she had had enough practice and had completed her medication theory workbook.

We commenced the drug round, I asked Abeni to talk through her systematic approach on working through the patients drug charts and explained what I expected to see her do. It became apparent then that Abeni was not clear regarding the allergy documentation on the front of the drug charts and when we went to the patient she did not realise how this tallied up with the patient wearing a red rimmed identity bracelet. I therefore began a teaching session on this subject. I decided then to halt the medication assessment as I felt Abeni needed to enhance her knowledge, and I explained this to her. Abeni was disappointed as she felt she was ready however accepted why I had decided to stop with the assessment, as allergy knowledge is a fundamental necessity to administering medication. We carried on with the drug round together and I then found that Abeni's drug knowledge needed improvement, I encouraged her to look medications up in The British National Formulary (BNF). I gave Abeni information myself and then asked her questions on what we had discussed, unfortunately Abeni could not always remember what I had said so I would encourage her again to re visit to BNF. I informed Abeni to always ask a patient if they have an allergy as part of her checks, and to ask the patient themselves for their date of birth and names rather than just reading the information off their identity bracelet and drug chart.'

Furthermore, the panel found that Witness 3's statement from 2 October 2018 is consistent with her witness statement:

'When we did the medication round together I went over all the areas and points she needed to consider whilst completing a medication round. I told the Registrant the checks that she needed to make such as asking a patient for their name, date of birth and if they had any allergies before administering the medication. The Registrant forgot to do this repeatedly and instead would just read the patients

name from the band on their wrists, each time I corrected her. The Registrant found it hard to retain information, when I asked her about this she explained that she found it overwhelming as there was a lot to remember.'

The panel also noted that, in relation to charge 2(b), Mrs Odebode admitted to being prompted on one occasion to check the allergies of patients she was administering medication for. It also noted that Mrs Odebode denies or cannot recall the other subsections of this charge. However, the panel was of the view that the evidence from Witness 3 and Nurse 1 is consistent and reliable. It was of the view that, on the balance of probabilities, Mrs Odebode required prompting to check all of the areas listed in charge 2. Therefore, the panel finds this charge proved.

Charge 3

"On the 2 October 2018 were unable to successfully complete a medication administration assessment."

This charge is found proved.

In reaching this decision, the panel took into account Mrs Odebode's admission. The panel, as set out in charge 1a)(iii), determined that Mrs Odebode failed to successfully manage her time in order to complete a medication administration assessment. The panel noted that Mrs Odebode has admitted to failing to successfully complete a medication administration assessment. Therefore, the panel finds this charge proved for the same reasons as charge 1a)(iii).

Charge 4

"On the 16 October 2018 incorrectly placed a blood pressure cuff on a patient."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and Mrs Odebode's written statement. The panel noted that in Mrs Odebode's written statement, she stated that:

> *'I deny that on 16 October 2018 I incorrectly placed a blood pressure cuff on a patient. I recall starting to put the blood pressure cuff onto the patient and the senior nurse who was mentoring me taking over and completing the task.'*

The panel heard the oral evidence of Witness 2 with regard to Mrs Odebode's submission. Witness 2 recalled the incident with clarity. She stated that when she initially observed the incident Mrs Odebode had already secured the cuff in the incorrect position, with the tubing over the elbow rather than the brachial artery. Witness 2 recalled that Mrs Odebode had already started to inflate the cuff to take a blood pressure reading before she intervened.

The panel considered the evidence of Witness 2 and it was satisfied that it was reliable and consistent. The panel therefore found this charge proved on the balance of probabilities.

Charge 5

> *"On the 15 October 2018 were unable to complete relevant patient documentation whilst monitoring blood glucose levels."*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3 and Mrs Odebode's written statement. The panel noted that, in her witness statement, Witness 3 states that:

'I had to remind the Registrant to fill out the relevant documentation when monitoring blood glucose. The Registrant informed me she had been a student nurse in Oxford and she admitted to me that she was finding it hard getting used to our Hospitals paperwork because the Hospital where she worked before in Oxford was paperless, so the documentation was stored electronically. The Registrant informed me she found it quite challenging to manage the large amount of paperwork on the Ward as she was not used to this.'

The panel was of the view that Witness 3's evidence, in regard to this charge, was consistent with her oral evidence and reliable.

The panel also noted Mrs Odebode's written statement, which states:

'At this time, I was getting used to completing paper documentation as I had come from a workplace where we used electronic documentation. I did however complete the relevant documentation.'

The panel considered the evidence, and was satisfied on the balance of probabilities that the evidence of Witness 3 was correct. The panel was of the view that, in light of the above, Mrs Odebode was unable to complete relevant patient documentation without being prompted whilst monitoring blood glucose levels on 15 October 2018. Therefore, the panel finds this charge proved.

Charge 6

"On the 15 October 2018 were unable to understand abbreviations contained within patient notes."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Witness 3 and Mrs Odebode's admission. The panel noted that, in her witness statement, Witness 3 stated:

> *'In the report summary and email I mention about the Registrant struggling to understand abbreviations so I also attached the Hospitals recognised Abbreviations List to this email and asked [Witness 1] to print it out for the Registrant. I also mentioned within the report summary the Registrant was finding all the documentation which needed to be completed on the Ward quite challenging.'*

The panel heard oral evidence from Witness 1, explaining how she had sat down with Mrs Odebode and explained the abbreviations to her. Witness 1 also noted that the student nurses were exposed to the use of medical abbreviations during their training and she would have expected Mrs Odebode to be familiar with the generically used medical abbreviations. The panel also heard oral evidence from Witness 3 that Mrs Odebode was unfamiliar with common, generic medical abbreviations and had been unable to understand and use them correctly in a discharge summary report.

The panel was of the view that Witness 1 and Witness 3's evidence, in respect of this charge, was consistent with their oral evidence and reliable.

The panel noted that Mrs Odebode, in her written statement, stated that:

> *'I was unable to understand abbreviations contained within patient notes. As a newly qualified nurse I was still familiarising myself with all abbreviations and had a booklet of abbreviations so I could check these.'*

The panel accepted Mrs Odebode's admission, and the evidence of Witness 1 and Witness 3, and found this charge proved.

Charge 7

"On the 15 October 2018 were unaware and/or unable to understand NEWS system."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 2 and 3, and Mrs Odebode's written statement. The panel noted that, in Witness 2's witness statement she says:

'I was also surprised at the fact that she was unaware of the NEWS (National Early Warning Score) as students know about this. The NEWS score is based on a patients observations to see whether they are deteriorating. For a qualified nurse not to be aware of this scoring system, this was surprise.'

In Witness 3's witness statement, she states:

'The Registrant was unfamiliar with the NEWS. The Registrant said she did not know what the parameters were for the NEWS or where she could find this information. I explained the concept of the VitalPac equipment to the Registrant.

The NEWS is a nationally used patient deteriorating monitoring assessment tool. I expect newly qualified nurses who have trained in the UK to have an understanding of this tool. I was shocked the Registrant did not have this level of knowledge. I appreciated the Registrant issues with travel, tiredness and settling into her new role may be hindering her concentration however her lack of knowledge regarding the NEWS was concerning.'

The panel was of the view that Witness 2 and Witness 3's evidence, in regard to this charge, was consistent with their oral evidence and reliable. The panel was of the view that Mrs Odebode should have been able to use and understand the NEWS system.

The panel also noted Mrs Odebode's written statement, in which she stated that she denied that she was unable to understand/use the NEWS system. However, the panel noted that, the performance report prepared about Mrs Odebode, dated 21 October 2018, states that Mrs Odebode *'required significant support'* and was *'not consistent in her ability to ..b) calculate the NEWS score accurately.'* this suggests that Mrs Odebode was still struggling with the NEWS system in January 2019. Therefore, the panel rejected Mrs Odebode's denial of this charge. The panel determined that, on the balance of probabilities, this charge is found proved.

Charges that arose on the Endoscopy Unit

> *'Between 2 December 2018 and 25 July 2019, whilst working in the Endoscopy Unit, failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you;'*

The panel considered the stem above relating to charges 8-18 and gave careful consideration to the standards of knowledge, skill and judgement that could be fairly expected of a newly qualified band 5 nurse, to practice without supervision. The panel considered that Witness 6 was very helpful in this area as her evidence is that she has *'assisted in the training and development of at least 20 new endoscopy nurses'* and that *'In total the Registrant spent five months of probation in a supernumerary capacity working alongside other more senior nurses. Usually a new band 5 staff nurse would be supernumerary for 2 weeks. They would work a week in admissions, a week in recovery and then progress to working in the scope rooms under the guidance of experienced staff. New staff progress at different rates but all new staff I have worked with so far have usually gained independence and competence in Admissions and Discharges within a week and are able to work safely in recovery as part of the team after having had one week of supervised/ supported practise. They are usually competent in basic scope room skills after a week in the procedure rooms (basic skills being putting up and taking down scopes, doing WHO checks and paperwork, completing tasks in room such as scanning*

the scope (scanning scope involves tracking label against the patient identity label) and taking and recording biopsies.'

Charge 8)

> *"Between the 28 May 2019 and the 12 July 2019 were unable to consistently go through the World Health Organisation ("WHO") checklist by;*
> *(a) Failing to ensure that patient notes match the WHO form*
> *(b) Failing to show the consent form to the patient*
> *(c) Failing to clarify the procedure with the patient*
> *(d) Failing to check whether the patient had any questions about the procedure*
> *(e) Failing to label biopsies taken during the procedure*
> *(f) Failing to ensure drug charts had been completed adequately*
> *(g) Failing to check a patient's name against their wrist band*
> *(h) Failing to document the number of specimens taken"*

This charge is found proved in its entirety except for charge 8)(b).

The evidence of Witness 6 was that she would normally expect a nurse in this situation to be able to use the WHO checklist competently after a week of training and supervision.

In reaching this decision, the panel took into account the evidence of Witnesses 4, 6 and 7 and Mrs Odebode's written statement.

Witness 6 observed Mrs Odebode regularly and on the 11 July 2018 she worked all day with the Registrant, this was at the end of her 8 month probation, she states *'the Registant was unable to meet the required standard of competence'* she goes into more detail explaining that even at that point:

'… she was completing the WHO document without actually fully performing any of the required checks. The Registrant did not check that she had the correct patient notes. She did not check the patient's wrist band had the correct name, date of birth and hospital number on it, such as checking she had the correct notes, checking that the patient's wristband had the correct details on, she did not check that the patient had someone to look after them overnight if having sedation. She did not check that the consent form was for the correct procedure and ensure that the patient understood what the procedure was; she just showed them the form and asked if the signature was theirs. I would have expected the registrant to explain the procedure and confirm that the patient's signature was theirs and that the understood the procedure they were about to undergo. She did not check that the correct name was on the screen for the reporting system.'

Witness 6 confirmed that contrary to the allegation in charge 8)(b), Mrs Odebode, on the 11 July 2019 was *'showing'* the consent form to the patient. On the basis of this evidence, the panel found charge 8)(b) was not proved on the balance of probabilities.

Witness 7, in her witness statement, stated that at 8 months Mrs Odebode *'was still inconsistent when completing nursing documentation in the scope room.' Describing 'inconsistency when labelling samples, checking patients' wrist bands when completing the WHO check list and completing the part of the WHO form relating to biopsies taken unless reminded to do so.'*

Witness 4, in her witness statement, stated the following:

'When the first patient came into the procedure room the Registrant was happy to go through the WHO Checklist. I was stood next to her whilst she was doing this. The Registrant began going through the checklist but had to be prompted to check the patients name against the wrist band to ensure that she had the correct patient. I had to remind her to do this on this occasion…

…After the procedure there are also final checks to go through on the WHO Checklist. This includes writing down the biopsies and number of specimens taken. Again I had to prompt her to write down whether any biopsies or specimens had been taken'

The panel noted that in her written submission, Mrs Odebode referred to the fact that she was signed off as competent to complete this checklist on 25 April 2019 and denied charges 8)(a),(b),(c),(f) and (g), and she stated that she cannot recall charges 8)(e) or (f). Mrs Odebode admitted charge 8)(d), namely failing to check whether the patient had any questions about the procedure, but only *'on occasion'*.

The panel considered the evidence carefully and determined that it accepted the evidence of witnesses 4, 6 and 7 which it found to be credible and reliable. The panel therefore found charge 8 proved in its entirety (with the exception of charge 8)(b).

Charge 9)(a)

"Were seen to handle and/or handover biopsy forceps incorrectly;
(a) On or around the 18 March 2019."

This charge is found proved.

The panel heard evidence from Witness 4 that Mrs Odebode was given training on the use of the biopsy forceps and an opportunity to handle them away from patients. Witness 6 said that the biopsy forceps were *'the most basic instrument in endoscopy'*. Therefore the panel considered it was appropriate for Mrs Odebode to be expected to meet this standard.

In reaching this decision, the panel took into account the report written by Witness 6 dated 18 March 2019 and Mrs Odebode's written statement.

The panel considered the evidence, and noted that, in Witness 6's report dated 18 March 2019, she stated:

> *'She did take some biopsies, but she was somewhat erratic with her use of the forceps and was therefore requested by the consultant and senior nursing staff to not wave them around and place them on the bed (dirty) to untangle them'*

The panel was of the view that Witness 6's evidence was consistent and credible and that this report is dated close to the time of the alleged incident, therefore it was reliable.

The panel noted that Mrs Odebode simply denied this charge. However, the panel was satisfied that on the balance of probabilities that the evidence of Witness 6 was correct and determined that this charge was found proved.

Charge 9)(b)

> *"(a) On the 11 July 2019."*

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement, and Mrs Odebode's written statement. The panel noted that Witness 6, in her written statement, said:

> *"During the lists on the 11th July 2019, the Registrant was witnessed by me to hand over the biopsy forceps in the open position on most occasions. During the morning list, the consultant had to request her to close the forceps prior to biopsy taking almost every time… At one point the Registrant randomly opened and closed the forceps several times prior to handing them over…"*

The panel was of the view Witness 6's evidence was consistent with her oral evidence.

The panel noted that Mrs Odebode denies this charge, however it was satisfied by the evidence of Witness 6 and finds this charge proved on the balance of probabilities.

Charge 9)(c)

"(c) On other unknown dates."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 4 and 7, and Mrs Odebode's written statement. The panel noted that that, in her witness statement, Witness 4 stated:

> *'During the procedure a scope (camera) was put into a patient. The Consultant wanted to take a biopsy from this patient. To do so the forceps, which have a sharp spike, are inserted into the scope to take a sample. The Registrant was responsible for taking the forceps out of the scope after the sample had been taken. When removing the forceps from the scope it is important to hold them in a specific way as they are sharp and are considered as a sharp instrument. You have to ensure you are careful removing them from the scope and support them as they have a sharp spike in the middle of them. I informed her that they had to be in the closed position. On this occasion the Registrant was unsteady with the forceps and waved them around. This was not a good performance from the Registrant as the forceps are sharp and can cause injury if not handled correctly.'*

Furthermore, the panel noted the evidence of Witness 7, who in her witness statement stated that:

'The other observed issue was the registrant not being able to handle the biopsy forceps safely. She would pass them over to the doctor whilst open.'

The panel was of the view that the evidence from both Witnesses 4 and 7 was credible and reliable.

The panel noted that Mrs Odebode admitted to this charge in her written statement, but she said that '*this did not happen as I developed into my role'.* The panel accepted Mrs Odebode's admission but noted that from the evidence, as set out in charge 9)(a), it was clear that this was still a problem on 11 July 2019. Therefore, the panel found that on the balance of probabilities, this charge is found proved.

Charge 10)(a)

"Were unable to recognise and/or state the location from which a biopsy had been taken from a patient;

(a) On the 11 July 2019"

This charge is found proved.

The panel heard evidence from Witness 6, that at its most basic level, this task involved listening to the endoscopist and recording what they said onto the specimen label, but that normally a nurse would soon be able to develop to recognise the different locations within the upper GI tract.

In reaching this decision, the panel took into account the evidence from Witness 6 and Mrs Odebode's written statement. The panel noted that, in her witness statement, Witness 6 stated:

'On the 11th July 2019… in every instance the registrant took biopsies during that day, the registrant requested me to review her labelling afterwards as she was not confident about what she herself had recorded… the registrant asked the endoscopist to repeat the biopsy location three or four times…

Despite the consultant and myself repeating what should go on each label, the Registrant still wanted me to check all of her labelling…'

The panel was of the view that Witness 6's evidence in regard to this charge was reliable and consistent with her oral evidence.

The panel noted that Mrs Odebode simply denied this charge. However, it was satisfied by the evidence of Witness 6 on the balance of probabilities and therefore found this charge proved.

Charge 10)(b)

"(b) On other unknown dates"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6, a report regarding Mrs Odebode's performance dated 24 July 2019, and Mrs Odebode's written statement. Witness 6 stated in her witness statement:

'From my point of view, having witnessed an almost identical situation with the Registrant during a list in May 2019, no discernible progress had been made in this skill (it was first mentioned in a report dated April 29th-May 10th 2019)'

The panel noted that in the report dated 24 July 2019, at the end of 8 months on probation, prepared by Witnesses 5, 6 and 7 it stated:

> *'[Mrs Odebode] struggles to coordinate the 3 aspects of taking biopsies. This includes physically taking the biopsy, understanding from the endoscopist the location of the sample and recording and labelling the details of the specimen on the pot, histology card and histology tracker book.'* and *'In regards to the location of the sample, [Mrs Odebode] needed to confirm location of the sample numerous times as she appeared unsure and unconfident with her labelling of the samples.'*

The panel noted that Mrs Odebode, in her written submissions admitted this charge, she stated that:

> *'I admit that towards the beginning of my employment in the Endoscopy Unit I did not recognise and/or state the location from which a biopsy had been taken. When I was in theatre at this early stage I did ask lots of questions because I wanted to learn. As I developed my knowledge if I was unsure I would always ask if I was unsure of anything.'*

The panel accepted the admission of Mrs Odebode and the evidence of Witness 6, and found this charge proved on the balance of probabilities.

Charge 11a)

> *"Were unable to manage and/or prioritise time when recovering patients in the Recovery Room;*
>
> *(a) On the 11 July 2019"*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and Mrs Odebode's written statement. The panel noted that in Witness 6's witness statement, she wrote:

> '*In the Scope room the Registrant struggled to organise herself, requiring direction, prompting and reminding in order to perform routine tasks… In the recovery area the registrant was not able to perform to the same standard as other staff in terms of recovering several patients concurrently…'*

The panel was of the view that Witness 6's written statement was consistent with her oral evidence, and was reliable and credible.

The panel noted that Mrs Odebode denied this charge. However, the panel was satisfied by the evidence of Witness 6 on the balance of probabilities, and therefore found this charge proved.

Charge 11)(b)

> *"(b) On other dates unknown"*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 7, a report regarding Mrs Odebode's performance dated 24 July 2019, and Mrs Odebode's written statement. The panel noted that, in Witness 7's witness statement, she stated:

> *'The Registrant had shown little improvement time management and prioritisation in the recovery area and scope room… There are approximately 50 patients per day going through recovery (25 in the morning and 25 in the afternoon). This workload should be split evenly between 3 trained nurses. Therefore workload could be*

described as 8 patients per nurse… The registrant was only able to recover 3 patients in the afternoon.'

The panel noted this is corroborated by a report regarding Mrs Odebode's performance in the Unit, dated 24 July 2019, which details similar concerns raised regarding time management and prioritisation as Witness 7. The panel was of the view that the report coupled with the evidence of Witness 7 is consistent, reliable and credible.

The panel noted that Mrs Odebode denied this charge and stated that she *'would check on all patients to ensure they were comfortable, checking their vital signs and giving them water when they felt ready to drink something. Once their vital signs were stable and they could take fluids, the patients would be taken to the patient lounge to get something to eat.'*

However, the panel was satisfied by the evidence of Witness 7 and the report from 24 July 2019 and found this charge proved on the balance of probabilities.

Charge 12)

"On the 11 July 2019 failed to set up suction equipment to manage a patient's airway correctly."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and Mrs Odebode's admission.

The panel noted that, in her witness statement, Witness 6 stated the following:

'During the list in the morning of July 11th 2019 I witnessed an incident involving the Registrant where she failed to set up equipment required to manage the patient's airway.

The consultant started the procedure (intubated the patient with the gastroscope) I prompted the registrant to suction the patient and then realised that she had no suction equipment to hand.'

The panel was of the view that the evidence from Witness 6 was reliable and credible. Further, it noted that Mrs Odebode admitted this charge. The panel therefore found this charge proved on the balance of probabilities.

Charge 13)

"On an unknown date and/or dates were unable to demonstrate competence to manage a patient's airway in that you needed prompting when suction was required."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and Mrs Odebode's admission.

The panel noted that, in her witness statement, Witness 6 stated:

'With regard to airway management: the Registrant did not achieve competence in this task. She required supervision and on all occasions where suction was required she needed prompting as she appeared not to recognise when the patient needed suction.'

The panel was of the view that the evidence from Witness 6 was reliable and credible. Further, it noted that Mrs Odebode admitted this charge and she stated the following:

'I confirm that at times I was not always able to judge this.'

Having regard to the evidence, and taking into account the admission made by Mrs Odebode, the panel found this charge proved.

Charge 14)

"On an unknown date and/or dates were unable to complete complex discharges."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6, the oral evidence of Witness 7 and Mrs Odebode's admission.

The panel noted that, in her witness statement, Witness 6 stated:

'At the 8 month point of probation the Registrant had not managed to achieve competence with management of complex discharges because she was unable to identify which specialist nurse she needed to refer to…'

The panel also noted that this was corroborated by Witness 7 who stated the following in her witness statement:

'… the Registrant was required to undertake 'complex discharges'… Despite the patient's condition being fully detailed in the Endoscopy report and this being explained to the Registrant she was still unable to retain the information and correctly identify which specialist nurse to refer the patient to…'

The panel noted that Witness 7, in her oral evidence, informed the panel that most newly qualified members of staff could carry out complex discharges within the first two months of working on the Unit. The panel was of the view that the evidence from both Witnesses 6 and 7 was cogent, reliable and consistent.

Further, it noted that Mrs Odebode admitted this charge. Therefore, the panel found this charge proved.

Charge 15)

> *"On an unknown date and/or dates were unable to cannulate unsupervised despite being signed off as competent in May 2019."*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 6 and Witness 7 and Mrs Odebode's written statement.

The panel had sight of Mrs Odebode's written statement in which she stated the following:

> *'I admit that I was not always able to cannulate unsupervised during my time working on the endoscopy unit despite being signed off as competent in May 2019. Even the most experienced nurses cannot cannulate a patient and after trying twice, they will call a colleague to try to prevent hurting the patient. There were occasions whilst I was working on the endoscopy unit when I did ask for colleagues to be present.'*

The panel noted that, in her witness statement, Witness 6 stated the following:

'b) Completion of the cannulation competency: the Registrant still required the support of another nurse up until 18th July 2019 when cannulating patients despite being signed off competent in the middle of May 2019'

The panel considered the oral evidence of Witness 6 who stated that Mrs Odebode *"never wanted to cannulate alone"* and *"was unable to set up equipment and needed help, she was never independent".*

The panel noted that this was corroborated by the evidence of Witness 7, who in her witness statement stated the following:

'Cannulation: Despite being signed off as competent, the Registrant was also not happy to complete cannulation independently. The Registrant would ask for someone to go in the room with her when carrying out cannulation on a patient.'

The panel was of the view that the evidence from both Witnesses 6 and 7 was consistent, credible and reliable. The panel therefore found, on the balance of probabilities, this charge is found proved.

Charge 16)

"On 13 June 2019:
(a) Were unable to administer an enema to Patient A correctly;
(b) Spilled or caused to spill liquid on Patient A"

This charge is found not proved.

In reaching this decision, the panel took into account the witness statement of Witness 11(Patient A), the oral evidence of Witness 6 and the written statement of Mrs Odebode.

The panel noted that Witness 11, in his witness statement, stated that he had been diagnosed with colorectal cancer, which he was receiving treatment for. He stated that, before receiving the enema from Mrs Odebode, his anus was sore due to this treatment. The panel noted that after liquid was spilled on Witness 11, as a result of the enema, he agreed with a senior nurse to self-administer.

The panel noted that Mrs Odebode, in her written statement, said that:

> *'The patient notes indicated he had a rectal condition which made it difficult for the enema to stay in for the required length of time patients are advised to keep the liquid in. He was very sensitive about every word and touch. I tried to ensure I did not cause any harm or discomfort. However, I was unable to administer the enema and spilled some liquid on the patient. I remember Patient A becoming extremely uncooperative.'*

The panel noted that this is corroborated by Witness 6, who in her oral evidence, recalled that Witness 11 was a particularly difficult patient to administer an enema to, and even the most experienced nurses struggled administering an enema to him.

The panel accepted the Mrs Odebode's admission, but was of the view that this enema was not easy to administer. In light of this, the panel determined that whilst Mrs Odebode was unable to administer the enema, this charge is found not proved, on the basis that Mrs Odebode did not *'fail'* to demonstrate the skill expected of a band 5 nurse to administer a complex enema to Witness 11.

Charge 17)

> *"On the 22 July 2019 incorrectly selected Pethidine to be administered to a patient when it should have been Midazolam."*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 8 and Mrs Odebode's admission.

The panel noted that Witness 8, in his witness statement, stated that:

> *'…the Consultant asked the Registrant to administer Midazolam to the patient. The Registrant picked up the syringe containing Pethidine with the light blue label on and was asked to stop by my colleague as she was about to administer the wrong medication to the patient.'*

The panel noted Mrs Odebode's admission, in which she stated that:

> *'I admit that on the 22 July 2019 I incorrectly selected Pethidine to be administered to a patient when it should have been Midazolam. These drugs are usually in different sized syringes, however on this occasion they were not (they were both in the same size syringe). I confirm that the correct medication was administered.'*

The panel accepted Mrs Odebode's admission, however rejected her explanation of events. The panel noted that Witness 8 said that the syringes were unlikely to have been the same size, he stated that he had never seen the syringes to be of the same size and that it would not be safe practice as it would make it very difficult to administer partial doses of medication if requested to do so by the consultant. Furthermore, the panel noted that Witness 8 stated that each syringe would be labelled clearly using the name of the medication, and the labels would be different colours for each medication. The panel accepted the evidence of Witness 8, as it found his evidence to be consistent, credible and reliable. The panel therefore determined that this charge is found proved.

Charge 18)

"In the week commencing the 25 February 2019, incorrectly removed the line containing the blood from the pump when not intravenous trained."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 10 and Mrs Odebode's witness statement.

The panel noted that, in Witness 10's written statement, she said that:

'During the week commencing 25 February 2019 I witnessed an incident involving the Registrant and a blood transfusion pump in the recovery area…

The incident I witnessed involved the Registrant opening up the front of the pump while the pump was attached to the drip stand to remove the line…

As the Registrant was not intra venous trained she should have told her seniors or told a band 5 nurse who was intra venous trained.'

The panel noted that this evidence was consistent with Witness 10's oral evidence, in which she said that Mrs Odebode incorrectly removed the line containing blood from the pump when not intravenous trained.

The panel noted that Mrs Odebode admitted this charge and she stated the following in her written statement:

'I admit that in the week commencing the 25 February 2019 I incorrectly removed the line containing the blood from the pump when not intravenous trained. I acknowledge that I should have called a senior nurse to let them know that the patient wanted to move from the bed to go to the toilet, however instead I allowed this and attempted to remove the line myself.'

The panel accepted the evidence of Witness 10 and had regard to Mrs Odebode's admission, it therefore found that this charge is proved.

Decisions and reasons on the facts relating to misconduct

Charge 19)

"That you a registered nurse;

On 13 June 2019 in relation to Patient A:

a. *Said words to the effect of "what are you doing?"*
b. *Shouted;*
c. *Behaved aggressively and/or rudely."*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witnesses 6 and 11(Patient A) and Mrs Odebode's written statement.

The panel noted that, in Witness 11's witness statement, he said that:

'The Registrant shouted at me "What are you doing?" whilst I was still in the fetal position. She said this in an aggressive and rude manner and stood up.'

The panel noted Mrs Odebode's written statement, in which she said:

'At the start of the admission process for Patient A I asked the patient if he had administered the required enema and he answered no. Therefore, as per the standard procedure, I led him to the recovery room to administer the enema. At no

time did I state, that the patient "was late", as I do not believe he was. Even where patients were late, I never highlighted this in my conversation with them. It was not unusual for patients to arrive without having administered their enema at home, so I was not taken by surprise that this patient needed his enema administered in the unit.

The patient notes indicated he had a rectal condition which made it difficult for the enema to stay in for the required length of time patients are advised to keep the liquid in. He was very sensitive about every word and touch. I tried to ensure I did not cause any harm or discomfort. However, I was unable to administer the enema and spilled some liquid on the patient. I remember Patient A becoming extremely uncooperative. I did not shout at him at any time, nor did I say words to the effect of 'What are you doing'. Instead I asked him calmly to calm down and try to stay still. I did not feel that at any time I was rude to the patient. Given how difficult the situation became, I sought the support of the Senior Sister who then completed the admission and administered the enema.'

The panel took into consideration all the evidence before it regarding Mrs Odebode. The panel was of the view that from the evidence it heard from the witnesses who had worked with her, being rude to patients appears to be out of character for Mrs Odebode. The panel noted that both Witnesses 6 and 8 said that Mrs Odebode was pleasant to work with and was kind to patients.

In making its decision, the panel noted that the evidence for this charge rests solely on the written evidence of Witness 11, who stated *'I was angry at this point'* because of the treatment he had received. The panel could not exclude the possibility that Witness 11's perception was influenced by the fact that he was in significant pain and was very upset and distressed.

The panel took account of Mrs Odebode's good character, and the burden and standard of proof. The panel was not satisfied, on the balance of probabilities, that the evidence of

Witness 11 was completely accurate and that Mrs Odebode's evidence was untrue, on that basis the panel found this charge not proved.

Charge 20) and 21)

> *"On the 10 July 2019 fell asleep whilst monitoring patient C."*
> *"On the 17 July 2019 fell asleep whilst monitoring patient B."*

These charges are found proved.

In reaching this decision, the panel took into account the oral evidence of Witnesses 8 and 9, DATIX incident reports from 2019 and Mrs Odebode's written statement.

The panel noted that an incident report was made on 10 July 2019, regarding Mrs Odebode falling asleep whilst monitoring Patient C. The incident report reads as follows:

> *'Abeni was part of the team performing the therapy list. She had been tasked with managing the airway. The case in questions was an ERCP patient, which was our fifth patient on the list. I observed her throughout the procedure from different positions not only being behind her, noticing her slowly nodding off became worried for the patient safety, as ERCPs are high risk procedures especially from an airway management point of View; if not properly managed can lead to serious harm. She was not simply closing her eyelids; instead she leaned on to the patient head and her right harm flopped down as she fell asleep.*
>
> *At this stage, the patient's safety was seriously compromised, so I intervened; so I approached her while she was asleep and tapped her on the shoulder telling her to wake up without even touching the stool she was sitting on.*
>
> *Once the procedure finished I went to speak with [Witness 7] which at the time was her Mentor in order to tell her what happened in the room. After [Witness 7] had a conversation with her, Abeni approached me telling me that she was shocked*

because she fell asleep and she couldn't believe it. She admitted the fact she fell asleep during a High risk procedure in front of me.'

The panel also noted that there was another DATIX incident report detailing another occasion on which Mrs Odebode is alleged to have fallen asleep (whilst monitoring Patient B):

'Statement regarding appeal: I was working with Abeni and one more person in the procedure room. It was one of our therapy rooms, so people carry out the therapeutic side of the procedure and the 3'd man does the airway. Abeni was designated to do the airway part for this list. The case in question was a difficult procedure and I was doing some training with the other member of the staff. The case was underway, when I could see Abeni was closing her eyes and she was nodding off.

I called out her name and she startled. I told her it is very important for her to be focus on what she is doing, since I was teaching someone else. The Doctor in the room reiterated my comment telling Abeni it is very important for her to fully present during the case. She needed to be aware to give reassurance to the patient since it was a complicated procedure and it is a risk to patient safety.

After the procedure was finished I approached our Matron and informed her about the situation that just happened and a Datix was completed.'

The panel noted Mrs Odebode's written statement, in which she stated that she did not fall asleep on either occasion. However, the panel rejected Mrs Odebode's position on this charge. The panel noted that both Witnesses 8 and 9 saw Mrs Odebode fall asleep whilst on shift. It noted that Witnesses 8 and 9 both described in detail that Mrs Odebode nodded her head downwards and she was startled awake when they touched her. The panel was of the view that both of these behaviours are synonymous with someone who had fallen asleep and had just been woken up.

The panel was satisfied that Mrs Odebode fell asleep on 10 July 2019 and 17 July 2019 but is not clear which incident was on which date. However, in light of the evidence above, the panel was satisfied that Mrs Odebode fell asleep whilst monitoring two different patient's airways on two separate days. Therefore, the panel found that, on the balance of probabilities, these charges are 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 lack of competence/misconduct and, if so, whether Mrs Odebode's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a Mrs Odebode'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 lack of competence/misconduct. Secondly, only if the facts found proved amount to lack of competence/misconduct, the panel must decide whether, in all the circumstances, Mrs Odebode's current fitness to practice is impaired.

In making its decision, the panel had regard to written and oral submissions from Mr Maskell.

Submissions on lack of competence

In coming to its decision, the panel should have regard to the NMC's guidance. The NMC describe lack of competence as usually involving an unacceptably low standard of professional performance, judged on a fair sample of work, which could put patients at risk.

Mr Maskell referred the panel to the case of *R (Calheam) v General Medical Council* [2007] EWHC 2606 (Admin), the court said;

> *"The phrase "professional deficient performance" 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"*

He then referred the panel to the case of *Holton v General Medical Council* [2006] EWHC 2960 (Admin), the court said:

> *"Deficiency is to be judged against the standard of his professional work that is reasonably to be expected of the practitioner…*
>
> *His performance should be that which is to be expected of a competent practitioner in the circumstances"*

Mr Maskell submitted that, at the material time, Mrs Odebode was working as a Band 5 Nurse. He submitted that Mrs Odebode's competence fell seriously short of the standards expected of a Band 5 Nurse.

Mr Maskell submitted that Mrs Odebode required a significant amount of support and in addition to remaining supernumerary for longer than expected (five months on Endoscopy Unit as opposed to between two to four weeks). He also reminded the panel that her six-month probation period was extended by three months. He submitted that the evidence from the witnesses heard by the panel confirm that Mrs Odebode required more time than

what is usually expected of a Band 5 registered nurse to ensure she was able to work safely and effectively.

Mr Maskell submitted that Mrs Odebode's approach to documentation was described as *"haphazard"*. He referred the panel to relevant pieces of evidence from the witnesses that support this. Further, he referred the panel to relevant evidence regarding Mrs Odebode's ability to conduct complex discharges.

Mr Maskell submitted that charges found proved and the evidence in this case clearly show that Mrs Odebode was not performing at the standard expected in multiple areas and her competence falls below what is expected of a newly registered band 5 Nurse.

Mr Maskell invited the panel to take the view that the facts found proved amount to lack of competence. He submitted the panel should have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Maskell identified the specific, relevant standards where he submitted Mrs Odebode's actions amounted to lack of competence.

Submissions on misconduct

In regard to misconduct, Mr Maskell submitted the panel should take into consideration 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.'*

Mr Maskell invited the panel to take the view that the facts found proved amount to misconduct. He submitted that the panel should have regard to the terms of the Code in making its decision.

Mr Maskell identified the specific, relevant standards where he submitted Mrs Odebode's actions amounted to misconduct. He submitted that, taking charge 20 and 21 together, falling asleep when managing a patient's airway during a procedure is undoubtedly serious and unreasonable behaviour.

Mr Maskell submitted that the charges proved amount to misconduct as Mrs Odebode's actions were serious and fell below what would have been expected of a reasonable and competent nurse.

Submissions on impairment

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

Mr Maskell submitted that, in regard to limb a) of *Grant,* although there is no evidence that any patient did suffer harm, Mrs Odebode's actions undoubtedly placed patients at an unwarranted risk of harm. Mrs Odebode did not manage her time effectively to ensure she completed mandatory training, she failed to set up suction equipment when it was required, she incorrectly removed an intravenous line which could have resulted in a free flow of blood entering the patient, and she fell asleep during two procedures during which she was in charge of managing the patients' airways. Therefore, Mr Maskell submitted that Mrs Odebode did place patients at an unwarranted risk of harm.

Mr Maskell submitted that, in regard to limb b) of *Grant*, the actions of Mrs Odebode brought the profession into disrepute and contravened the expectation of a registered nurse behaving professionally. He submitted that Mrs Odebode failed to reach the

standards expected of her and failed to manage her time effectively, leading to a limit of her ability to care for patients.

Further, he submitted that the panel should consider the need to uphold proper standards and public confidence, and whether these would be undermined if impairment were not found. The NMC submits that these would be undermined if impairment was not found in the case of a registered nurse who was found to have a lack of competence in a number of areas despite an unprecedented amount of support and fell asleep during two procedures.

Mr Maskell informed the panel that Mrs Odebode is currently working as a registered nurse three days a week in Sunnyside Nursing Home. She began working in this role in October 2021. Considering this, Mr Maskell submitted that the panel may wish to consider risk of repetition. He submitted that the charges occurred despite Mrs Odebode being supervised and mentored extensively, and happened over an extended period of time. Therefore, he submitted that there is a risk of repetition in this case.

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

Decision and reasons on lack of competence

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

"1.2: make sure you deliver the fundamentals of care effectively
1.4: make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
2.1 work in partnership with people to make sure you deliver care effectively

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

7.1 use terms that people in your care, colleagues and the public can understand

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

8.2: maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

9.2: gather and reflect on feedback from a variety of sources, using it to improve your practice and performance…

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

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

13.5 complete the necessary training before carrying out a new role

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

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

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

The panel was of the view that the charges relating to lack of competence are serious, as they relate to Mrs Odebode failing to learn essential, basic and wide-ranging nursing skills required for her to practice safely and effectively, despite months of direct support and mentoring. The panel noted that Mrs Odebode failed to manage her time to ensure that she was able to practice as a Band 5 registered nurse. The panel noted that, even when

Mrs Odebode was signed off as competent, she still required additional support in order to complete the tasks required of her. The panel was of the view that the charges highlight that Mrs Odebode was unable to complete her work in a structured and timely manner.

In addition, the panel noted that numerous safeguarding measures were put in place to ensure that Mrs Odebode would not cause harm to patients, and was constantly supervised. The panel noted that an action plan was implemented to ensure that Mrs Odebode was observed carrying out every day essential nursing tasks. Therefore, although no harm came to patients, this was more due to the vigilance of her colleagues than her own actions, the panel was of the view that Mrs Odebode's actions did fall seriously short of the standards expected of a registered nurse.

Decision and reasons on misconduct

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

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

> *"1.2: make sure you deliver the fundamentals of care effectively*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *13.4 take account of your own personal safety as well as the safety of people in your care*
> *19: Be aware of, and reduce as far as possible, any potential for harm associated with your practice*
> *19.1: take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures"

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 charges are serious, as they relate to falling asleep on two separate occasions whilst managing patients' airways. The panel found that Mrs Odebode's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the lack of competence/misconduct, Mrs Odebode's 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. 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 found that limbs a, b and c of *Grant* are relevant for their decision making.

The panel finds that patients were put at risk and, although no physical and emotional harm was caused as a result of Mrs Odebode’s lack of competence/misconduct, there was a high risk that harm could have been caused to patients. Mrs Odebode’s misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered Mrs Odebode’s admissions and her reflective pieces. The panel was of the view that Mrs Odebode has not provided evidence that she has full insight into the charges found proved at the Hospital. It noted that her reflective pieces do not address how Mrs Odebode’s actions have affected the nursing profession,

patients, patients' families and her colleagues. It also noted that, even though Mrs Odebode admitted to some of the charges, they were not full admissions. Rather, in regard to the majority of her admissions, she provided excuses as to why she did what she did, rather than admitting outright to the charge and expressing remorse. Therefore, the panel was of the view that Mrs Odebode has demonstrated variable insight into the charges.

The panel was satisfied that Mrs Odebode's failings in this case are capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Odebode has strengthened her practice. The panel took into account Mrs Odebode's training certificates dated between 2018 and 2021, the references she has received from her current employers and her competency records dated between 2018 and 2019. The panel was of the view that, although this shows some improvement in Mrs Odebode's practice, this was not enough to satisfy the panel that Mrs Odebode has strengthened her practice in the areas of concern highlighted by the charges.

In light of the above, the panel is of the view that there is a risk of repetition in this case. The panel noted that, in one of her references from her current employers, it states that:

> *"… we have been working on her with practice and our action plan for the areas that still need to be improved"*

The panel was of the view that this is vague and does not directly say which areas Mrs Odebode needs to improve on. Therefore, the panel noted that there is nothing before it today that would suggest that Mrs Odebode does not continue to pose a risk to patients. In light of this, and coupled with the seriousness of the charges found proved, the panel determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required as a well-informed member of the public would be concerned to find that Mrs Odebode was not found to be impaired, considering the wide-ranging and serious nature of the charges. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Odebode's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months, with a review. The effect of this order is that the NMC register will show that Mrs Odebode's registration has been suspended.

Submissions on sanction

Mr Maskell informed the panel that in the Notice of Hearing, dated 4 April 2022, the NMC had advised Mrs Odebode that it would seek the imposition of a 12 month suspension order, with a review, if the panel found her fitness to practise currently impaired. Mr Maskell submitted that a 12 month suspension order would ensure that the public are protected and the wider public interest is upheld.

Decision and reasons on sanction

Having found Mrs Odebode's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanction 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 insight into failings
- Persistent failings in basic nursing skills over a period of 8 months
- Two identical incidents of misconduct over a short period of time
- Conduct which put patients at risk of suffering harm

The panel also took into account the following mitigating features:

- Mrs Odebode has made some admissions to charges
- Demonstrated emerging insight into some of the areas of concern

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Odebode's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel considered that Mrs Odebode's case was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Odebode's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG factors that may make a conditions of practice order appropriate, 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.*

Before making its decision on this, the panel noted that Mrs Odebode has been working as a registered nurse at a care home with an interim conditions of practice order imposed on her practice. The panel considered how Mrs Odebode has worked with the current conditions imposed. Unfortunately, with the very limited information available to the panel, it was unable to make an adequate assessment of any progress made by Mrs Odebode. It noted that the references Mrs Odebode provided for the panel to consider suggest that there remains some concerns around her learning and development.

The panel gave the SG serious consideration. The panel was of the opinion that there are many identifiable areas of retraining Mrs Odebode could undertake and that she might be

willing to retrain in the areas of concern identified. Further, the panel considered that Mrs Odebode did not have any deep-seated attitudinal issues. However, the wide-ranging and serious concerns in this case that demonstrate a general incompetence that is not currently compatible with a conditions of practice order. At this stage, the panel was not confident that Mrs Odebode has the insight and reflection required to retrain successfully in order to practice safely and effectively, without constant prompting and supervision from another registered nurse. It noted that, even though Mrs Odebode received constant support from her mentors and supervisors during her extended supernumerary and probationary periods at the Hospital, her actions were repeated and she required continuous support to ensure no harm was caused to patients. The panel paid particular regard to the evidence of Mrs Odebode's unpredictable lack of competence, for example:

- Despite being signed off as competent to conduct cannulations, she still asked for another registered nurse to ensure she was doing it correctly
- *"Haphazard"* completion of WHO checklists, without carrying out the safety checks set out within it.
- Incorrectly removing an open intravenous line from an infusion pump despite not being trained to do so.

The panel noted that it was this unpredictability which made it difficult for Mrs Odebode's mentors and supervisors to allow her to practice unsupervised whilst at the Hospital. Furthermore, the panel noted that several witnesses informed them that Mrs Odebode was unable to learn at the rate expected of her, and would often forget relevant information a short time after being given it. In light of this, the panel was of the view that, at this point, there are no practical or workable conditions that could be formulated that would ensure patients are protected, given the nature of the charges in this case.

Furthermore, the panel concluded that the placing of conditions on Mrs Odebode's registration would not adequately address the seriousness of the lack of competence/misconduct in 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;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was of the view that Mrs Odebode's misconduct was serious, in that she fell asleep on two separate occasions whilst monitoring patients' airways. The panel was of the view that, in the absence of insight, reflection and retraining, there is a risk of repetition in this case. However, notwithstanding this, the panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go 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 Mrs Odebode's case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause Mrs Odebode. However this is outweighed by the public protection and wider public interests in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the lack of competence/misconduct.

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:

- Your attendance at the review of this suspension order.
- Evidence of any up-to-date Continuing Professional Development (CPD) and any learning from this in relation to the charges.
- Reflective piece that addresses your insight into the charges, with particular regard to how you would act differently if you were put in the same situations (as seen in the charges) again, and how your actions have affected the nursing profession, your colleagues, patients and their families.
- Evidence of keeping up-to-date in clinical nursing subjects, including but not limited to; medications management and administration, complex discharges, and record keeping.
- Testimonials from any future employer.
- Copy of your action plan and details of any progress made at Sunnyside Care Home to date.

This will be confirmed to Mrs Odebode 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 Mrs Odebode's own interest until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Maskell. He submitted that a corresponding interim order is necessary and that the NMC apply for an interim suspension order for a duration of 18 months. He submitted that an interim suspension order is necessary to protect the public and uphold the wider public interest. Mr Maskell submitted that 18 months would allow time for an appeal process, if relevant, to conclude.

Decision and reasons on interim order

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

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

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

That concludes this determination.