Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 24 – Friday 28 April 2023

Virtual Hearing

Name of registrant:	**Stella Adenike Adeleke**
NMC PIN:	02C1502O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – April 2002
Relevant Location:	Camden
Type of case:	Misconduct
Panel members:	Wayne Miller (Chair, Lay member) Terry Shipperley (Registrant member) Mary Golden (Lay member)
Legal Assessor:	George Alliott
Hearings Coordinator:	Rene Aktar
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Ms Adeleke:	Present and represented by Adewuyi Oyegoke
Facts proved by admission:	Charges 1, 2, 3, 4, 5a), 5b) 6a), 6c) 8, 9, 10, 11, 12, 13, 14
Facts not proved:	Charges 6b), 7
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

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

At the outset of the hearing, Mr Joshi (on behalf of the Nursing and Midwifery Council), made a request that parts of this case be held in private on the basis that proper exploration of your case involves reference to your health and personal matters. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Oyegoke indicated that he supported the application to the extent that any reference to your health and personal matters should be heard in private.

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 when issues relating to your health and personal matters are raised.

Details of charge

That you, a registered nurse, on a home visit to Patient A, on the night of 13 to 14 January 2021:

1. Failed to ask Person A pre visit COVID-19 screening questions. **(proved by admission)**

2. Removed an incontinence pad from beneath Patient A without replacing it. **(proved by admission)**

3. Did not escalate that you had not replaced Patient A's incontinence pad. **(proved by admission)**

4. Left Patient A with no or inadequate protection from soiling. **(proved by admission)**

5. Left the home visit without notifying Person A that:
    a. Patient A was awake; **(proved by admission)**
    b. Patient A did not have an incontinence pad **(proved by admission)**

6. Recorded incorrectly on Patient A's record:
    a. Person A's name; **(proved by admission)**
    b. Patient A's diagnosis; **(not proved)**
    c. A full handover was received by Person A in a phone call at 9pm. **(proved by admission)**

7. Did not record assessments of Patient A's condition during his care. **(not proved)**

8. Did not record telephone calls made to Person A prior to the visit. **(proved by admission)**

9. Did not record adequately details of Patient A's holistic care. **(proved by admission)**

10. Did not sign your amended entries on Patient A's notes. **(proved by admission)**

11. Did not escalate your concerns regarding Patient A's refusal of care to the out of hours District Nurses. **(proved by admission)**

12. Did not obtain assistance from the out of hours District Nurses. **(proved by admission)**

13. Did not provide an adequate handover note to your employer. **(proved by admission)**

14. Did not raise an incident report with your employer. **(proved by admission)**

Decision and reasons on application to admit hearsay of Person A into evidence

Mr Joshi made an application under Rule 31 to allow the written statement of Person A into evidence. He submitted that since the incident occurred, Patient A has passed away. He submitted that Person A was originally willing to attend and give evidence at a previously scheduled hearing, however the previous hearing did not go ahead. Mr Joshi submitted that Person A appeared to be quite concerned about the fact that the hearing did not go ahead and appears to have lost interest in the hearing.

Mr Joshi submitted that Person A does not resile from her evidence or what she says, and that the passing of Patient A is upsetting and traumatic. He submitted that this is why Person A appears to have disengaged with the proceedings. Mr Joshi submitted that Person A was contacted again this morning, however Person A has made it quite clear that she does not want to have further contact with the NMC over this matter.

Mr Joshi made reference to an email sent by Person A to the NMC dated 21 December 2022, stating:

> *"I am confirming from this day forward I will not be proceeding any further into 2023 in respect of the case being brought by the Midwifery Council in respect of the nurse Miss Adeleke. In which I was asked to give evidence.*
>
> *The council has enough photographic evidence and what they decide to do/proceed is their business.*
>
> *I do not wish to be contacted any further about this case - which I did not bring - nor be informed of any further procedures or actions. Thank you."*

Mr Joshi submitted that he was not made aware that Person A would not be attending until the morning of the hearing and that the panel should take into consideration that there is further evidence in relation to the allegations that are still being denied. He submitted that there are records of interviews with you that are produced by the second witness. Mr Joshi made reference to *Thornycroft v NMC* 2014 EWHC 1565 and *EL Karout v NMC* 2019 EWHC 28.

Mr Joshi submitted that there is supporting evidence available from the second witness. He submitted to the panel that the evidence is demonstrably reliable and that there are some means of testing its reliability. He submitted that at this stage, the panel should look to consider the evidence in relation to Person A.

Mr Oyegoke opposed the hearsay application made by Mr Joshi. He submitted that the panel should consider the weight of the issue in fairness of the parties. Mr Oyegoke submitted that there would no longer be the opportunity for you or the panel to test the evidence in cross examination. He submitted that in fairness to you, the panel should consider that Person A is not present.

Mr Oyegoke submitted that in terms of the opposition, the panel should consider that the witness statement contains a complaint, and that there are communication exchanges between Person A and the employers of Ms Adeleke. Mr Oyegoke submitted that the admissions were not only because of the witness statement but were based on the proceedings that are taking place before the witness statement was drafted.

The panel heard and accepted the advice of the legal assessor.

The panel took into account that it is regrettable that the NMC had only notified the parties and the panel about Person A’s nonattendance at the start of the hearing.

The panel took into account the following factors:

- The source is a good source in that Person A was a first-hand witness to the events she gives evidence about.
- There is nothing at this stage that suggests she is unreliable.
- You have admitted 14 of the 17 factual allegations and only 3 remain contested.
- Person A's evidence is not the sole or decisive evidence of the remaining charges as there is other supporting evidence.
- The reason for Person A's absence is disappointing but understandable.
- In the event that the panel admitted the hearsay evidence, it will still be open to the panel to decide what if any weight should be placed upon it once it has heard your evidence.
- The evidence is relevant to the charges remaining.
- The witness statement was made within 10 months of the incident.

Having considered fairness and the submissions made, the panel concluded that in all the circumstances it would not be unfair to admit the evidence. The panel will apply such weight to the evidence as it sees fit in due course.

Background

The allegations arose at the time you were working as a registered nurse for Marie Curie Centre ('the Organisation'). You were referred to the NMC on 19 April 2021 by DR, Associate Director, from the Organisation.

The alleged facts are as follows:

On the night of 13 and 14 January 2021, you were allocated to provide care to Patient A throughout the night at Patient A's home. Patient A was an elderly patient whose health had taken a sudden decline in the days prior to that night. Patient A's daughter, Person A, was also present at Patient A's home. Person A had a cough and even though they had reported it to be a stress cough, Person A had recently taken a Covid-19 test and was awaiting results. The Organisation asked Person A to keep themselves away from you in a separate room.

Prior to your arrival at Patient A's home, you called Person A on three occasions although Ms 2 had told the panel that it was usual to make only one phone call prior to arriving at the patient's home. These conversations left Person A feeling anxious about you and the care you would be able to provide to Patient A.

On arrival to Patient A's home, you failed to ask Person A the prescribed Covid-19 screening questions, which were part of the Organisation's policy. Shortly after your arrival, Person A went to bed and left you to care for Patient A. On two occasions throughout the night, you woke Person A up to ask her questions. The first was regarding Patient A's incontinence pads. Person A informed you that you should not be changing these as the care agency will change it in the morning. You then asked Person A for a towel. Person A verbally directed you to find the towels.

On the second occasion, you informed Person A that you were not feeling well and that you had to leave the property. Person A says you had this conversation in front of Patient A and this was inappropriate. You left Patient A's residence at around 03:50. On leaving Patient A's residence, you failed to escalate his care to the out of hours nursing team and you failed to inform your manager the following day. Person A says they quickly checked on Patient A and then went back to bed. Person A re-checked on Patient A around 25 minutes later and found Patient A "*in a mess*". Person A says Patient A:

- had his big and second toe stuck around Person A's pole on the bedstead
- was left lying on a soiled bed sheet as his incontinence pad had been removed
- had no pillow or sheet under his head or feet
- was lying diagonally across the bed.

Person A took photographic and video evidence of how Patient A had been found in his bed. Person A made a complaint about your care on 14 January 2021. A local investigation was commenced and was progressed to a disciplinary hearing. You resigned prior to the outcome of the disciplinary.

Decision and reasons on facts

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

- Ms 2: Clinical Nurse Manager at the Organisation.

At the conclusion of the NMC case, Mr Oyegoke made a submission of no case to answer.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Oyegoke that there is no case to answer in respect of Charges 5a) and 6b). This application was made under Rule 24(7). Mr Oyegoke submitted that there was either no evidence to find these charges proved or that the evidence was weak so that a properly informed panel would not be able to find the charge proved.

Mr Oyegoke submitted that in relation to Charge 5a), there is no evidence before this panel to prove this allegation and also because there is only one person that made this allegation. He submitted that Person A has opted not to attend and so the evidence before the panel cannot be tested and there also would not be any opportunity for you to question Person A. Mr Oyegoke submitted that the element of Charge 5 is weak.

Mr Oyegoke submitted that in relation to Charge 6b), the evidence put before the panel is weak and therefore is contradictory. He submitted that this is unfair to you.

Mr Oyegoke made an application of no case to answer in regard to two out of the three remaining Charges, Charge 5a) and Charge 6b).

Mr Joshi submitted that he disagreed with Mr Oyegoke's position and asserted that there was sufficient evidence to proceed such that you have a case to answer on both charges.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was only considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you have a case to answer.

The panel noted that, in relation to Charge 5a), there was evidence in two meetings with your employer in the disciplinary process. These were held following the incident where you admitted that you left the home without notifying Person A that Patient A was awake. The panel therefore determined that there is a case to answer for this charge.

In relation to Charge 6b), the panel took account of Patient A's care notes and noted that although the diagnosis had not been recorded exactly as outlined in Person A's statement, what had been recorded was not technically incorrect. The panel therefore determined that there is no case to answer for this charge.

The panel, of its own volition, went on to consider the wording of Charge 7). It took into account Patient A's care notes and noted that some assessments of his condition had been recorded by you at various times when you were in the home. The panel therefore determined that there is no case to answer for this charge.

Accordingly, Charges 6b) and 7 are not proved.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Oyegoke, who informed the panel that you made full admissions to charges 1, 2, 3, 4, 5b), 6a), 6c), 8, 9, 10, 11, 12,13 & 14. Following the panel's determination that there is a case to answer on Charge 5a), you admitted this charge.

The panel therefore finds charges 1, 2, 3, 4, 5a), 5b), 6a), 6c), 8, 9, 10, 11, 12, 13 & 14 proved in their entirety, by way of your admissions.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions and evidence on misconduct and fitness to practise

Mr Joshi invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The NMC code of professional conduct: standards for conduct, performance and ethics (2004)' (the Code) in making its decision.

Mr Joshi submitted that due to the nature of the concern, the panel would need to consider how you have acted in the past or how liable you are to act in the future to put a patient at unwarranted risk of harm. He submitted that this relates to public protection issues. He made reference to parts of the Code as well as the case of *CHRE v NMC & Grant*.

Mr Joshi reminded the panel of the concerns he had identified previously, namely:

- Poor communication with Person A
- Failure to keep clear and accurate records
- Failure to follow the COVID-19 policy from the Organisation
- Failure to treat Patient A with dignity
- Failure to communicate effectively with colleagues and seek assistance

Mr Joshi reminded the panel that nurses are expected to practise kindly, safely and professionally when delivering care to a patient.

Mr Joshi submitted that if the panel were to find impairment, then it should consider the seriousness of what has taken place and whether Patient A came to any harm. He asked the panel to consider the risk of repetition in the future.

You gave evidence to the panel under oath about the circumstances of the charges and what you have been doing since the incident. Mr Oyegoke first asked you to explain the communication and record keeping issues that Ms 2 had brought to the panel's attention during her live evidence, and you explained how they had been resolved when you were new to the Organisation.

You were extremely remorseful throughout your live evidence about the incidents that occurred. You stated that due to the COVID-19 regulations at the time, [PRIVATE].

Mr Oyegoke took your through your evidence using the following headings for each area of discussion:

- Handover at the start of the shift
- Communication
- Compassion
- COVID-19 screening questions
- Criticism of care
- Record keeping
- Handover when you left the home

You acknowledged your failings in all of the above areas, recognised that your standard of practice fell below that of expected of a registered nurse and repeatedly apologised for all of the issues raised.

Mr Oyegoke outlined to the panel the training that you have undertaken since the incident, the fact that you have been working consistently in a hospital setting via an agency. Mr Oyegoke drew the panel's attention to references, testimonials and positive shift feedback presented in your exhibit to the NMC.

Mr Joshi and the panel had the opportunity to ask further exploratory questions from you. Mr Joshi, in cross examination, asked questions to clarify your understanding of your job description and duties and responsibilities at the time of the incidents and determine how you would act differently now and in the future. Mr Joshi concluded that following your admissions to the allegations, your fitness to practise is impaired.

Mr Oyegoke asked you to give specific examples of incidents that you have dealt with effectively over the past few months.

The panel further explored what was happening at the time of the incident. You explained what your hopes and intentions are for the future and what strategies you would put in place to prevent a similar incident from occurring again.

Mr Oyegoke submitted that it is for the professional judgement of the panel to make a decision on misconduct and impairment. He referred to parts of the Code that you acknowledged you had breached.

Mr Oyegoke 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. He made reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). Mr Oyegoke reminded the panel that this was a single episode which he submitted was remediable. He made reference to your reflective piece, the fact that you made early admissions and apologies, and that you have demonstrated continuous remorse for your failings.

Mr Oyegoke reiterated about the further training you have undertaken some of which was sponsored by yourself. You have continued to work as a nurse, you have received positive feedback and references which you have produced. He submitted that you have fully remediated your failings and that the risk of repetition is very remote. He concluded therefore that your fitness to practise is no longer impaired.

Mr Joshi submitted that the concerns around your practice still remain. He submitted that the answers you gave in response to cross examination did not fully address the particular points and were vague in their content. He submitted in conclusion, that the NMC's position is that your fitness to practise is currently impaired.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on misconduct

The panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

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

*'**1 Treat people as individuals and uphold their dignity***
1.1 Treat people with kindness, respect and compassion
1.2 Make sure you deliver the fundamentals of care effectively
1.4 Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns
2.1 Recognise when people are anxious or in distress and respond compassionately and politely
2.5 Respect, support and document a person's right to accept or refuse care and treatment
2.6 Recognise when people are anxious or in distress and respond compassionately and politely

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

3.1 Pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

4 Act in the best interests of people at all times

4.4 Tell colleagues, your manager and the person receiving care if you have a conscientious objection2to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

7 Communicate clearly

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

7.4 Check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

8 Work co-operatively

8.2 Maintain effective communication with colleagues

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

8.6 Share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

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

10.3 Complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary jargon or speculation

13 Recognise and work within the limits of your competence

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

13.2 Make a timely referral to another practitioner when any action, care or treatment is required

13.3 Ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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

20 Uphold the reputation of your profession at all times

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered that taking each charge individually, the facts admitted may not have been on their own sufficiently serious to constitute professional misconduct. However, taken together and in light of the range of deficiencies in your practice, the panel concluded that the facts admitted did fall significantly short of the standard expected of a registered nurse and were sufficiently serious to constitute misconduct.

The panel noted that your communication prior to, during and after the incident was poor. In particular, you failed to adequately communicate with Person A in the first instance and this then subsequently led to Person A becoming anxious before you even arrived at the home. Your failures in communication compromised your ability to deliver safe and effective care to Patient A, whom the panel noted was vulnerable and whose condition had been deteriorating rapidly. The panel further noted that the information you passed onto your manager was inadequate.

You did not follow the Organisation's protocol for COVID-19 screening and could not recall what this was during the employer's investigatory interview. During the pandemic, a documented process was introduced which meant that this should have been standard practice which if followed would have maximised the safety of Patient A, Person A and yourself. The panel was particularly concerned that you put your own interests above all other matters and noted that you had acknowledged that you had allowed your emotions to override your judgement.

You admitted that your care for Patient A fell well below that which was expected of a nurse. The panel noted that, from your records, you were not able to cope with Patient A's needs but failed to seek assistance from colleagues. The panel was particularly concerned that you left the house mid shift without handing over the care of Patient A, a vulnerable person, to other healthcare professionals. You did not communicate this fact to Person A which meant that Patient A did not receive the appropriate care until later that morning.

The panel acknowledged that records were made by you during your shift but took into account that you acknowledged that they were inadequate. The panel were of the view that your record keeping was of a poor quality which increased the risk for Patient A's subsequent care.

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. Patient A had a right to expect better care and Person A should have been better supported. Your actions on the night in question meant that this was severely lacking and fell seriously short of the conduct and the standards expected of a registered nurse and amount to misconduct.

Decision and reasons on impairment

At the start of the hearing, Mr Oyegoke on behalf of you accepted misconduct and that your fitness to practice is impaired. However, by the time he made his submission on impairment, his position had changed.

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

The panel took into account that nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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*
>
> d) *…;*

The panel considered the ‘test’ as set out above, and found that limbs a), b) and c) were met.

The panel found that Patient A was put at risk of harm by your actions and that Person A was not afforded the right to a peaceful period of respite. Further, the panel determined that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel concluded that your fitness to practise was impaired on public protection and public interest grounds.

Regarding insight, the panel considered that you made early admissions and that you have acknowledged your failings. The panel took into account that you are continuing to practise as a nurse and that you have undertaken training.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not you have sufficiently strengthened your practice.

The panel took into account the unprecedented circumstances of the COVID-19 pandemic. The panel also noted that protocols were in place to safeguard members of staff providing care. However, the panel was concerned that you did not follow those protocols [PRIVATE].

The panel is of the view that the risk of repetition remains. You did not reassure the panel that the risk of repetition is less during your live evidence when some of your answers to specific questions were rather vague. Further, the panel noted that you have not been exposed to a similar situation, as on the night of the incident, but have only worked in a fully supported hospital setting. The panel further took into account that there is no guarantee that you would not be working on your own again in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that 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 these particular circumstances. The panel therefore determined that a finding of impairment is necessary on public interest grounds.

Submissions on sanction

Mr Joshi reminded the panel about the NMC Sanctions Guidance (SG) and the need for the panel to consider the seriousness of the facts found proved and the context in which the incident occurred. He made reference to the need to be proportionate when considering which sanction was appropriate and to take into account the impact of any sanction on the nurse.

Mr Joshi outlined a number of aggravating factors, including the abuse of trust and putting a patient at unnecessary risk of harm. Mr Joshi submitted to the panel that a member of the public would be appalled by the state that Patient A was allegedly left in as reflected in the photographs taken by Person A of Patient A.

Mr Joshi further outlined a number of mitigating factors including your early admissions and apologies at the time of the incident and the steps you have taken to remediate since that time. Mr Joshi submitted that both public protection and public interest concerns are engaged in this case.

Mr Joshi submitted that while the appropriate sanction in this case might be a suspension order, it should be no less than a conditions of practice order.

Mr Oyegoke reminded the panel of the list of sanctions open to them. He submitted that members of the public have a right to protection when receiving care. He further submitted that there is a public interest in a nurse being able to return to practice.

Mr Oyegoke acknowledged that the main aggravating features of this case were the involvement of a vulnerable person and a distressed relative. He went on to list mitigating factors which included your early admissions, your remorse, the insight you have demonstrated and the training you have undertaken. He also noted that this incident occurred on a single shift during the COVID-19 pandemic.

Mr Oyegoke submitted that the appropriate sanction in this case would be no more than a conditions of practice order.

Decision and reasons on sanction

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

The panel makes clear that, whilst the photographs are undoubtedly distressing, they were taken some time after you left the home, and consequently the panel could not proceed on the basis that they reflect the state you left Patient A in.

The panel took into account the following aggravating features:

- You were responsible for a vulnerable patient and put him at risk of harm
- You caused distress to the Patient's relative
- You have yet to develop full insight
- You demonstrated a lack of judgement
- You exhibited a lack of compassion
- You abdicated your responsibility for the care of Patient A and the support of Person A
- The incident involved a number and range of deficiencies in care.

The panel also took into account the following mitigating features:

- You had limited knowledge of Patient A and his circumstances prior to the night in question
- You were working during the COVID-19 pandemic and had your own personal vulnerabilities to infection based on [PRIVATE] and ethnicity
- You made early admissions and apologies
- You have demonstrated partial insight into your failings
- The incident occurred during a single shift

- You have produced a number of references and shift feedback documents.

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 your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice. However, the panel acknowledged that you will need to gain support in the workplace and this may be more challenging while working as an agency nurse.

The panel had regard to the fact that this incident happened just over two years ago and that, other than this incident, you have had an unblemished career of a number of years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel went on to consider the other available sanctions, but was of the view that imposing a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

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

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

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

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

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

3. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

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

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

6. You must not work in a patient's own home unless accompanied by a registered nurse of Band 5 or above.

7. You must ensure that you are working at all times on the same shift as, but not always directly observed by a registered nurse of Band 5 or above.

8. You must keep a personal development log every time you undertake a shift outlining:
    - Date and time of each shift
    - The working environment and clinical specialty

9. You must identify a registered nurse of Band 6 or above as a clinical supervisor and work with them to create a personal development plan (PDP). Your PDP must address the concerns about:
    - Demonstrating care and compassion in the delivery of nursing care
    - Communication with patients, relatives and colleagues
    - Identifying when you need further support and assistance
    - Record keeping
    - Adherence to guidelines/protocols/procedures and policies

    As part of this process you must:
    - Engage with your clinical supervisor monthly to ensure that you are making progress towards the aims set out in your PDP
    - send your case officer a copy of your PDP when it has been developed
    - send your case officer a report from your supervisor showing your progress towards achieving the aims set out in your PDP, prior to any reviewing hearing.

10. You must keep a reflective practice profile. The profile will:
    - Detail any challenging situations encountered
    - Set out the nature of the care provided to deal with these challenges
    - Contain feedback from a registered nurse of Band 6 or above on how you managed these challenges

    You must:
    - Send a copy of your reflective practice profile prior to any reviewing hearing.

The period of this order is for 12 months.

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

Any future panel reviewing this case would be assisted by:

- Your attendance at the hearing
- A reflective piece detailing how you have addressed the particular concerns raised in this case
- Up-to-date employment references and testimonials

This will be confirmed to you in writing.

Decision and reasons on interim order

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

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

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

That concludes this determination.