Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
26 – 30 June 2023,
3 July 2023

Virtual Hearing

Name of Registrant:	Olatokunbo Adebayo
NMC PIN	09K0542E
Part(s) of the register:	RNA: Adult nurse, level 1 (15 September 2011)
Relevant Location:	London, Swansea and Neath Port Talbot, Shrewsbury
Type of case:	Misconduct
Panel members:	Wayne Miller (Chair, Lay member) Patience Adobea McNay (Registrant member) Isobel Leaviss (Lay member)
Legal Assessor:	Nigel Pascoe KC
Hearings Coordinator:	Anya Sharma (26 June 2023), Chandika Cheekhoory-Hughes-Jones (27 – 30 June 2023) Rene Aktar (3 July 2023)
Nursing and Midwifery Council:	Represented by Rebecca Butler, Case Presenter
Miss Adebayo:	Not present and not represented
Facts proved:	Charges 1a, 1b, 2a, 2b, 2c, 3a, 3b, 3c
Facts not proved:	Charges 1c, 3d
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (18 months)

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Adebayo was not in attendance and that the Notice of Hearing letter had been sent to Miss Adebayo's registered email address by secure email on 4 May 2023.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons for proceeding in the absence of Miss Adebayo

The panel next considered whether it should proceed in the absence of Miss Adebayo. It had regard to Rule 21 and heard the submissions of Ms Butler who invited the panel to continue in the absence of Miss Adebayo. She submitted that Miss Adebayo had voluntarily absented herself.

Ms Butler referred the panel to email correspondence between Miss Adebayo and the NMC dated 10 May 2023, which states that Miss Adebayo has received the notice of this

substantive hearing via email and has confirmed that she will not be attending this hearing.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Miss Adebayo. In reaching this decision, the panel has considered the submissions of Ms Butler 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 Miss Adebayo;
- Miss Adebayo has informed the NMC that she has received the Notice of Hearing and that she will not be attending this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness has been warned to attend the hearing virtually on Day 1 give live evidence, three others are due to attend virtually in subsequent days;
- 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 five years ago;
- 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 Miss Adebayo in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Adebayo's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

'That you, a registered nurse:

1) *Between April 2018 and June 2019 whilst working as an agency nurse at different hospitals, you failed to maintain safe medication management and administration in that:*

    a) *During a night shift on 22 May 2018 you failed to administer medication to one or more patients;*
    b) *During a night shift on 23 June 2019 you pre-potted medication for one or more patients;*
    c) *On 24 August 2018 you gave Patient A oramorph when they should have been given subcutaneous morphine;*

2) *Between 22 May 2018 and 23 May 2018 you failed to support and/or work collaboratively with colleagues in that you:*

   a) *Refused to assist Colleague 1 with a patient and said "it is not my job" or words to that effect;*
   b) *Failed to assist colleagues by not attending to patient call bells despite being available;*
   c) *Told Colleague 1 that you were too busy to assist with patient care while using your personal phone during a busy shift and/or whilst patients required assistance;*

3) *Between 22 May 2018 and 23 May 2018, demonstrated poor patient care in that you:*

   a) *Were rude and dismissive towards a patient who had asked for assistance and said "it's not my job, it is not my area, I suggest you keep buzzing until the helper comes" or words to that effect;*
   b) *Refused to assist one or more patients who had asked for and/or required assistance;*
   c) *Ignored call bells from one or more patients when you were available to assist;*
   d) *Failed to conduct observations on one or more patients despite being asked by colleagues to do so;*

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

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

At the outset of the hearing, Ms Butler made an application that this case be held partly in private on the basis that proper exploration of Miss Adebayo's case might involve

reference to her health. The application was made pursuant to Rule 19 of the '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 Miss Adebayo's health if and when such issues are raised.

Decision and reasons on application to admit hearsay evidence in relation to Witness 3

The panel heard an application made by Ms Butler under Rule 31. Ms Butler informed the panel that the written witness statement of Witness 3 contains reference to parts of hearsay evidence and that she was making an application to allow those parts of Witness 3's written witness statement into evidence as they are relevant to charge 1c.

Ms Butler stated that that the hearsay evidence consists of a complaint made by a Health Care Assistant ('HCA'), Colleague B, and reported to a Ward Manager ('Colleague C') and exhibited by Witness 3. She told the panel that Witness 3 will be giving live evidence, but not Colleague C nor the HCA.

Ms Butler stated that the panel has before it two accounts of events, one exhibited by Witness 3, and one from Miss Adebayo in her written response to the Hospital as part of its investigation into the alleged incident. She submitted that the panel is dealing with professionals who were in a clinical environment and that there would be no motive for Witness 3 to be falsifying or fabricating evidence against Miss Adebayo. She submitted that it is a matter for the panel to determine whether this hearsay evidence is decisive and whether its admission would be fair to all parties. She stated that Miss Adebayo was given

prior notice and that she has had the opportunity to see all the evidence upon which the NMC would be relying.

Ms Butler informed the panel that the NMC has taken reasonable steps to service first-hand evidence. She stated that the only witness for this incident regarding end-of-life care was Colleague B (the HCA) who left the Trust soon after the incident occurred. She stated that the Trust confirmed that they do not have any contact details for Colleague B nor any details of where Colleague B went after she left the Trust.

The panel accepted the advice of the legal assessor.

The panel gave the application in regard to Witness 3 serious consideration. The panel noted that Witness 3'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 her.

The panel considered whether Miss Adebayo would be disadvantaged if the hearsay evidence identified were allowed into evidence.

The panel noted that there are two different versions of the alleged incident before it. It noted that, on one hand, as a result of Miss Adebayo's decision to absent herself from the hearings, it cannot question Miss Adebayo, and on the other hand, Colleague B was not called to give evidence. It took into account that the NMC had taken reasonable steps to trace Colleague B as a potential witness to this hearing and noted that its attempts were unsuccessful.

The panel found that the hearsay evidence identified is relevant to charge 1c and that it is not the sole and decisive evidence as the panel has before it Miss Adebayo's written response to the Hospital's internal investigations. It also had patient records.

The panel considered that Miss Adebayo had been provided with a copy of Witness 3's statement and exhibits and has had the opportunity to make submissions. The panel had already determined that Miss Adebayo had chosen voluntarily to absent herself from these proceedings; she would not be in a position to cross-examine this witness. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the identified hearsay evidence to be admitted but it would take particular care to give appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit hearsay evidence in relation to Witness 4

Ms Butler informed the panel that the written witness statement of Witness 4 includes hearsay evidence in that it relates to what patients told Witness 4 the following morning. She told the panel that Witness 4 is attending to give live evidence, but that the patients will not be attending to give live evidence. She explained that the NMC is relying on the evidence of the healthcare professionals rather than the patients involved in the alleged incidents. She stated that there is no evidence before the panel to indicate that Witness 4 would have any ulterior motive and that there is no suggestion that Witness 4's evidence is fabricated. She reminded the panel that Miss Adebayo was given the opportunity to respond to Witness 4's written witness statement and that she was given prior notice.

The panel accepted the advice of the legal assessor.

The panel gave the application in regard to Witness 4 serious consideration. The panel noted that Witness 4'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 her.

The panel considered whether Miss Adebayo would be disadvantaged if the hearsay evidence identified were allowed into evidence. It considered the hearsay evidence to be relevant to charges 1, 2 and 3, but it was not the sole and decisive evidence, because the panel would be hearing live evidence from Witness 1, who had been on shift with Miss Adebayo at the time.

The panel considered that Miss Adebayo had been provided with a copy of Witness 4's statement and its exhibits and has had the opportunity to make submissions. The panel had already determined that Miss Adebayo had chosen voluntarily to absent herself from these proceedings; she would not be in a position to cross-examine this witness. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the identified hearsay evidence, but it would take particular care to give appropriate weight once the panel had heard and evaluated all the evidence before it.

Issues Regarding Proceeding in Absence

On day 5 of the hearing, before handing down on facts, the panel observed that the proof of service bundle before it included an email dated 7 May 2023 from Miss Adebayo in which she had stated as follows:

> *"…I won't be attending the hearing based on the reasons I stated from my previous email…"*

In the interests of completeness and fairness, the panel remarked that it did not have anything before it elaborating on the *"reasons"* for Miss Adebayo's voluntary absence. The panel considered, in fairness to Miss Adebayo who is not represented, to seek clarification from the NMC on the reasons which Miss Adebayo referred to in her email dated 7 May 2023.

The NMC then provided the panel with further on-table documents consisting of email exchanges dated 21 and 22 March 2023 between Miss Adebayo and the NMC case officer, in which Miss Adebayo elaborated on the reasons behind her voluntary absence, including on her health issues.

The panel considered that these email exchanges dated 21 and 22 March 2023 and was of the view that these documents should have been put before it earlier in the process. The panel noted within the correspondence that the NMC had told Miss Adebayo in an email dated 22 March 2023 *"I will ensure that the information you have provided is presented to the panel".* In the interests of fairness to Miss Adebayo, the panel invited submissions from Ms Butler as to the significance and relevance of these documents with regards to proceeding in absence. It also asked if there are any further documents that should have been brought to the attention of the panel.

Ms Butler submitted that, the panel having already decided to proceed in absence on Day 1 of this hearing, it is unclear as to whether this panel has the jurisdiction to revisit that decision.

Ms Butler submitted that this case dates back to 2019, when Miss Adebayo was first alerted to the concerns four years ago. She submitted that the issue of relevance to proceeding in absence is *"what the indication is from Miss Adebayo as to her willingness to participate in the current proceedings"*. [PRIVATE]

Ms Butler stated that Miss Adebayo is engaging with the NMC; she is aware of the proceedings against her and has repeatedly stated that she did not want to attend this hearing. Ms Butler submitted that her submissions with regard to proceeding in absence remain the same. She stated that no adjournment had been requested by Miss Adebayo on account of her ill health. Ms Butler stated that Miss Adebayo's most recent communication with the NMC was on *"last Friday"* [PRIVATE] and only confirmed that she was not going to attend this hearing.

[PRIVATE] Ms Butler also informed the panel that communication with Miss Adebayo is ongoing and there is an intention to again contact her to ascertain if she is willing to attend the sanction stage (if this stage is reached). Having sought further instruction, Ms Butler confirmed that there is no other material to be brought to the attention of the panel.

The panel accepted the advice of the legal assessor. The panel was advised that the information set out in the email exchanges dated 21 and 22 March 2023 between Miss Adebayo and the NMC, should have been provided to this panel earlier in the proceedings. He advised that nevertheless, and particularly in light of the clear submission made by on behalf of the NMC, that he is satisfied the panel would not be properly criticised for proceeding in the absence of Miss Adebayo. He advised that in absence of the email exchanges dated 21 and 22 March 2022, this panel's position does not change. He stated that he is equally satisfied that the panel cannot be criticised for proceeding as it has done to determine the charges and that this information would not have impacted on its resolution.

The legal assessor further advised that the email exchanges dated 21 and 22 March 2022 could be beneficial for the panel's deliberation at the future stage of misconduct and impairment and/or sanctions stage if the panel does proceed to these stages. He advised that any further information which the NMC has, must be provided to this panel, in the interests of Miss Adebayo, who is unrepresented and who reports being ill with an intermittent condition. He advised that, on that basis, it seems that the panel can continue adopting the principles of fairness which underline these proceedings.

The panel took account and accepted the legal advice. The panel considered that the emails were relevant to considering whether to proceed in Miss Adebayo's absence, but having seen them, it remained satisfied that it remained fair to do so for the reasons previously stated. The panel was cognisant of the need to progress matters in the interests of Miss Adebayo.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Butler on behalf of the NMC and Miss Adebayo's written responses.

The panel has drawn no adverse inference from the non-attendance of Miss Adebayo. 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, under affirmation, from the following witnesses called on behalf of the NMC:

- Witness 1: HCA on Ward 8 at Singleton Hospital (Swansea) at the material time
- Witness 2: Ward Sister at University College London Hospital ('UCLH') at the material time
- Witness 3: Professional Lead for the temporary staffing department at the Royal Shrewsbury Hospital ('Shrewsbury Hospital') at the material time
- Witness 4: Acting Ward Manager on Ward 8 at Singleton Hospital (Swansea) at the material time

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC. The panel did not have any written response from Miss Adebayo, except for the written response of Miss Adebayo submitted to Shrewsbury Hospital during the course of its internal investigation and produced by the NMC in the testimony of Witness 4. The panel also took this written response into account.

The panel then considered each of the disputed charges and made the following findings. In reaching its decision, the panel took into account that the passage of time constituted a challenge for the witnesses and in their recollection of some aspects of the alleged incidents. The panel took into account that a considerable length of time has passed between when the incidents allegedly occurred, the time when the relevant statements were taken, and finally when live evidence is being heard at this hearing.

Charge 1

'Between April 2018 and June 2019 whilst working as an agency nurse at different hospitals, you failed to maintain safe medication management and administration in that:

a) *During a night shift on 22 May 2018 you failed to administer medication to one or more patients;'*

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statement and exhibits of Witness 1 and Witness 4, including the Bank Nurse Performance Monitoring Form dated 22 May 2018.

The panel noted that in Witness 1's written witness statement, she stated as follows:

‘I left the medication just in case something happened. Due to being a Healthcare Support Worker (HCSW) I am not allowed to administer medication. I thought that the staff nurse was returning to give her the medication as she was a stroke patient. I approached the nurse but she chose to ignore me. I did observations on my own for all the patients. I informed her of this and she would make the noise “urgh”. She should have administered the medication…’

In her oral evidence, Witness 1 told the panel that Miss Adebayo was leaving medication on the patients’ tables and was not staying with patients to ensure that the respective medication was taken, and therefore administered. The panel noted that the evidence of Witness 4 regarding Miss Adebayo’s responsibilities and duties, was consistent with the evidence of Witness 1.

The panel was satisfied, on the evidence before it, that Miss Adebayo had the responsibility and the duty of care to administer medication to patients and to ensure that medication was administered. The panel heard that Miss Adebayo left the medication on the tables for patients and left the room.

The panel found Witness 1 to be a credible witness and she gave a first-hand account of what she had seen.

On the basis of the evidence before it, the panel found that it is more likely than not that Miss Adebayo failed to maintain safe medication management and administration as described in charge 1a.

The panel, therefore, found charge 1a proved, on the balance of probabilities.

Charge 1b

'Between April 2018 and June 2019 whilst working as an agency nurse at different hospitals, you failed to maintain safe medication management and administration in that:

b) During a night shift on 23 June 2019 you pre-potted medication for one or more patients;'

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statement of Witness 2, including the Inpatient nurse medication administration guide, the medication administration part 1 D (DOPS), the safe medicines management medication, and the medicines management policies.

The panel noted that in Witness 2's written witness statement, she stated as follows:

'On the ward the medications are stored in the treatment room. The normal process would be to scan the patient and then scan each medication as you dispense them into a pot. Then the nurse would take the dispensed medication to the patient to administer. Once with the patient, the nurse should verbally check the patient's name, date of birth, hospital number and allergies against the electronic drug chart to ensure the patient is correct. This would be the same process for each patient, one patient at a time.'

The panel took into account the following from the Safe medicines management medication Administration policy:

'…medication must never be prepared in advance of its immediate use'.

The panel also noted the following from the Feedback form dated 23 June 2019, produced by Witness 2:

> *'I observed that Adebayo had a tray of medications on her computer.*
>
> *The medications had been dispensed into medicine pots and then she had written the patients bed number on the pots.*
>
> *The tray contained at least 4 different patients morning medications.*
>
> *I asked Adebayo about this and asked how she had scanned the patient and the medications. She said she had just scanned the medications. I pointed out this this is not safe practice. She gave no response to this.*
>
> *I am concerned that Adebayo was not following the basic principles of safe medication administration in trying to dispense multiple patients medications at once.*
>
> *Furthermore with the EPIC system that we use in this hospital it is a requirement that she should scan the patients ID band and then the medications before administration which couldn't not have been done.'*

Witness 2 told the panel that irrespective of the *'EPIC system'*, it was not safe practice to 'pre-pot' medications for more than one patient; they should be done for one patient at a time and administered before moving onto the next patient in order to minimise the risks of patients receiving incorrect medications.

The panel did note that the date on the incident report seems to have been recorded as a date prior to the alleged incident. When queried, Witness 2 stated that she remembers doing the report on the same day of the alleged incident, before finishing her shift. In her oral evidence, Witness 2 accepted that despite the length of time that had transpired since

the incident, she was that shocked by what she saw Miss Adebayo doing that she can, to this day, still clearly visualise it. The panel found the evidence of Witness 2 to be clear and consistent.

The panel was satisfied, on the evidence before it, that Miss Adebayo had the responsibility and the duty of care to maintain safe medication management and administration, a fundamental principle of nursing.

On the basis of the evidence before it, the panel found that it is more likely than not that Miss Adebayo failed to maintain safe medication management and administration as described in charge 1b.

The panel, therefore, found charge 1b proved, on the balance of probabilities.

Charge 1c

> *'Between April 2018 and June 2019 whilst working as an agency nurse at different hospitals, you failed to maintain safe medication management and administration in that:*
>
> *c) On 24 August 2018 you gave Patient A oramorph when they should have been given subcutaneous morphine;'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence and written witness statement of Witness 3, and its exhibits, including the Patient Record, Miss Adebayo's written response produced by Witness 3 and the email dated 2 October 2018.

The panel took into account that the patient records demonstrate that Patient A was prescribed both Oramorph and subcutaneous morphine medications and that Patient A

was, in the days preceding the alleged incident, given both medications. It noted that the prescription showed that Oramorph was given during the day prior to the night shift in question.

The panel noted that the incident report was dated two months after the alleged incident which had been reported by Colleague B (the HCA) to Colleague C. Witness 3 confirmed that she had not been present during the alleged incident and was relying on a report written by Colleague C, based on reports made to her by Colleague B (the HCA) who had been on a shift with Miss Adebayo.

The panel noted that as both medications had been prescribed, it was Miss Adebayo's responsibility to make a clinical and pragmatic judgment during the night about which one of the pain reliefs to administer.

Whilst the panel noted the hearsay evidence that Colleague B had reported hearing, namely *'…it* [the medication] *was sitting in her throat'*, it was not satisfied that this was sufficient evidence for it to conclude that Miss Adebayo had made a clinical error and should have instead administered subcutaneous morphine. For example, there might be other explanations for the sound that Colleague B heard, and the panel did not hear live evidence from Colleague B. Miss Adebayo had stated in her response to the Hospital that the patient had been fully awake and *'able to swallow the medication without any difficulty'*. In her account, Miss Adebayo stated that at 04.40, *'she was still able to swallow the medication'*.

The panel heard from Witness 3 that when Miss Adebayo (as an agency nurse) was administering medication to Patient A, she should have been in the company of another nurse, namely a substantive nurse. The panel noted that whilst this is portrayed to the panel as being a substantial concern, an ordinary person would expect that the substantive nurse should have raised this, if there was a concern.

The panel was also of the view that Miss Adebayo had a degree of discretion as to what pain relief medication to administer to Patient A and had provided a reasonable account of her actions and decisions which tallied with the patient records.

On the basis of the evidence before it, the panel was not satisfied that the NMC has discharged its burden of proof in relation to this charge.

The panel, therefore, found charge 1c, not proved, on the balance of probabilities.

Charge 2a

'Between 22 May 2018 and 23 May 2018 you failed to support and/or work collaboratively with colleagues in that you:

a) Refused to assist Colleague 1 with a patient and said "it is not my job" or words to that effect;'

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statement of Witness 1 and exhibits, including the Job Description for the role of Staff Nurse Band 5 ('the Job Description') and the bank nurse performance monitoring form produced by Witness 4.

The panel noted that in Witness 1's written witness statement, she stated as follows:

'I asked the nurse if she could help with bed 4. She said it's not her job and said that it was my job. She then walked off. I needed help with a patient in room 6, bed 4 because she was a stroke patient and required all care. This involved two people attending to her needs, and this was explained to the nurse.'

The panel found the evidence of Witness 1 clear, and consistent with her written witness statement. It heard that when Witness 1 asked Miss Adebayo for help and the reasons behind her request, the latter walked away.

The panel took into account the Job Description for the role which Miss Adebayo held. Whilst the panel was not sure whether Miss Adebayo would have personally seen this Job Description at the material time, it was of the view that Miss Adebayo ought to have been aware of the principles of patient centred care and collaborative working. On the basis of the evidence before it, the panel was satisfied that there was a requirement on Miss Adebayo to assist Witness 1 with patient needs if she was available to do so.

The panel found that Miss Adebayo's behaviour fell below the standards expected of a registered nurse with regards to the duty of care to patients and the duty towards supporting and assisting colleagues. It was of the view that members of the public expect a registered nurse to support and assist their colleagues.

The panel, therefore, found charge 2a proved, on the balance of probabilities.

Charge 2b

'Between 22 May 2018 and 23 May 2018 you failed to support and/or work collaboratively with colleagues in that you:

b) Failed to assist colleagues by not attending to patient call bells despite being available;'

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statement of Witness 1 and Witness 4, and exhibits.

The panel took into account the following from the written witness statement of Witness 1:

> *'I went on my break and I went to inform her of this. She said that she was busy. She was on her personal phone and the buzzers were going off and she was not answering them. When the buzzers were going off the staff nurse should answer the buzzers which are on their side. Also, there are other staff members either on a break or busy with their patients.*
>
> *When I came back from my hour break, the buzzers were still going off. It appeared as though she had not attended to any of the patients in the hour I was on my break. After returning from a break, patients were very distressed and informed me that no one had answered the buzzers since I went for a break.'*

Witness 1, in her oral evidence, told the panel about the circumstances surrounding the alleged incident. She told the panel that it was a *"hectic night"* and testified about the impact on her of Miss Adebayo's behaviour throughout the shift. The panel found that Witness 1's evidence was clear, and consistent with her written witness statement.

The panel also took into account the following from the written witness statement of Witness 4:

> *'…There is also an expectation that all staff answer patient's call bells throughout the shift and to attend to any needs the patients may have…*
>
> *Reports from Colleague 1 stated that both she and her patients found the registrant to be rude, unhelpful and ignorant to their needs. Colleague 1 stated that even when asked directly by herself or the nurse in charge, the registrant still did not assist in answering call bells or assisting with hygiene needs. She actively encouraged patients to call for another member of staff, despite standing in the same room.*

I spoke with three patients the following day, who said they felt they had to speak up as they did not want anyone vulnerable to suffer at the registrants' hands. They felt she was a risk to patients' health and safety, as she did not listen to even their basic needs. They felt there was a potential for a patient to come to harm through the registrants in-actions.'

During her oral evidence, Witness 4 told the panel that responding to the call bells is everyone's responsibility and that once activated by the patient, they create a *"grating sound that cannot be ignored."*

On the basis of the evidence before it, the panel was satisfied that there was a requirement on Miss Adebayo to assist Witness 1 and that she had repeatedly not responded to patient call bells despite being available.

The panel found that Miss Adebayo's behaviour fell below the standards expected of a registered nurse with regards to the duty of care to patients and the duty towards supporting and assisting colleagues. It was of the view that members of the public expect a registered nurse to support and assist their colleagues.

The panel, therefore, found charge 2b proved, on the balance of probabilities.

Charge 2c

'Between 22 May 2018 and 23 May 2018 you failed to support and/or work collaboratively with colleagues in that you:

c) Told Colleague 1 that you were too busy to assist with patient care while using your personal phone during a busy shift and/or whilst patients required assistance;'

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statement and exhibits of Witness 1.
The panel took into account the following from the written witness statement of Witness 1:

> *'I went on my break and I went to inform her of this. She said that she was busy. She was on her personal phone and the buzzers were going off and she was not answering them. When the buzzers were going off the staff nurse should answer the buzzers which are on their side. Also, there are other staff members either on a break or busy with their patients.*
>
> *When I came back from my hour break, the buzzers were still going off. It appeared as though she had not attended to any of the patients in the hour I was on my break. After returning from a break, patients were very distressed and informed me that no one had answered the buzzers since I went for a break.'*

Witness 1, in her oral evidence, told the panel about the circumstances surrounding the alleged incident. The panel found that Witness 1's evidence was clear, and consistent with her written witness statement.

The panel also took into account the oral evidence of Witness 4 who told the panel that Witness 1 is an experienced member of staff, and it was unusual to see her upset. The panel heard that when Witness 1 escalated her concerns to Witness 4, Witness 4 spent some time talking to Witness 1 and completed a formal performance monitoring form dated 22 May 2018 (which the panel had sight of) which resulted in the cancellation of Miss Adebayo's subsequent night shifts.

The panel heard that Miss Adebayo was the only staff member available to help and that she did not help Witness 1. It heard that the reason for which Miss Adebayo was not answering buzzers appears to be because Miss Adebayo was *"on her phone all night"*.

On the basis of the evidence before it, the panel was satisfied that there was a requirement on Miss Adebayo to assist Witness 1.

The panel found that Miss Adebayo's behaviour fell below the standards expected of a registered nurse with regards to the duty of care to patients and the duty towards supporting and assisting colleagues. It was of the view that members of the public expect a registered nurse to support and assist their colleagues.

The panel, therefore, found charge 2c proved, on the balance of probabilities.

Charge 3a

'Between 22 May 2018 and 23 May 2018, demonstrated poor patient care in that you:

e) *Were rude and dismissive towards a patient who had asked for assistance and said "it's not my job, it is not my area, I suggest you keep buzzing until the helper comes" or words to that effect;'*

This charge is found proved.

The panel found charge 3a proved, on the balance of probabilities, to the extent that Miss Adebayo was dismissive towards the patient by using the words contained in the charge.

In reaching this decision, the panel took into account the oral evidence and written witness statement of Witness 1, and Witness 4, and the exhibits, including the Bank Nurse Performance Monitoring Form dated 22 May 2018.

The panel took into account the following from the written witness statement of Witness 1:

'By the time I got to the patients in room 5, the patients were complaining about her. One of the patients was crying. When I came out of room 5 I could hear shouting.

The lady in room 6 had lost a leg and she couldn't get to the toilet. She asked the nurse if she could help her to the toilet and the nurse ignored her. I could hear her asking again and repeating herself. I went to see what was happening and heard the nurse say "it's not my job, it is not my area, I suggest you keep buzzing until the helper comes and they will come and help you.'

The panel also noted the following from the written witness statement of Witness 4:

'I have not worked directly with the registrant. I came on shift on 23 May 2018 as acting ward manager at the time. Colleague 1, Healthcare Assistant approached me first thing in the morning and told me she had worked with the registrant and she had been very unhelpful. She advised there had been multiple complaints from patients on the night shift. Colleague 1 advised me that she asked the registrant to help her but did not receive it.

During her shift the registrant was expected to dispense oral and intravenous medications as prescribed (in line with Swansea Bay University Health Boards Band 5 Staff Nurse Job Description which I exhibit as Exhibit LT/01 and The NMC Code), assist with attending to her patients' hygiene needs, deliver regular pressure area care and perform routine or repeat observations. There is also an expectation that all staff answer patient's call bells throughout the shift and to attend to any needs the patients may have. While she completed most of her primary duties by administering appropriate medication and documentation accordingly, one patient said she failed to administer prescribed analgesia – even when asked for it directly and another patient said she witnessed her leaving medications unattended in a pot at a patient's bedside and only provided assistance when the other patients in the room informed her that said patient was unable to take them independently, thus prompted her to assist. She failed in other fundamental areas of care such as assisting with hygiene needs and providing basic human comfort.

Reports from Colleague 1 stated that both she and her patients found the registrant to be rude, unhelpful and ignorant to their needs. Colleague 1 stated that even when asked directly by herself or the nurse in charge, the registrant still did not assist in answering call bells or assisting with hygiene needs. She actively encouraged patients to call for another member of staff, despite standing in the same room.'

The panel found that, on the balance of probabilities, there was insufficient direct evidence of Miss Adebayo being rude towards this particular patient, albeit that she had generally been described as rude by Witness 1 and Witness 4 had reported that patients had described her as rude.

Nevertheless, the panel was satisfied on the balance of probabilities, that there was sufficient evidence of Miss Adebayo not responding to this patient's requests for help because in Miss Adebayo's words, it was *"not her job"*. The panel was satisfied that this amounted to being dismissive towards this patient.

Taking into account the circumstances surrounding the context and circumstances surrounding the incident, the panel found that Miss Adebayo demonstrated poor patient care.

The panel, therefore, found charge 3a proved.

Charge 3b

'Between 22 May 2018 and 23 May 2018, demonstrated poor patient care in that you:

b) Refused to assist one or more patients who had asked for and/or required assistance;'

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statement of Witness 1 and Witness 4, and the exhibits, including the Bank nurse performance monitoring form.

The panel took into account the following from the written witness statement of Witness 1:

> *'The patients were buzzing and complaining about the nurse. The patients were informing me that she was leaving the medication in their room and they were asking her questions but she was not answering them. The nurse was making a noise like "urgh" and shaking her heard. There were 4 patients in room 6, 3 patients in room 5 and two side rooms who all informed me that the nurse was rude and ignorant.*
>
> *By the time I got to the patients in room 5, the patients were complaining about her. One of the patients was crying. When I came out of room 5 I could hear shouting. The lady in room 6 had lost a leg and she couldn't get to the toilet. She asked the nurse if she could help her to the toilet and the nurse ignored her. I could hear her asking again and repeating herself. I went to see what was happening and heard the nurse say "it's not my job, it is not my area, I suggest you keep buzzing until the helper comes and they will come and help you.'*

The panel also took into account the following from the written witness statement of Witness 4:

> *'I have not worked directly with the registrant. I came on shift on 23 May 2018 as acting ward manager at the time. Colleague1 , Healthcare Assistant approached me first thing in the morning and told me she had worked with the registrant and she had been very unhelpful. She advised there had been multiple complaints from patients on the night shift. Colleague 1advised me that she asked the registrant to help her but did not receive it.*

During her shift the registrant was expected to dispense oral and intravenous medications as prescribed (in line with Swansea Bay University Health Boards Band 5 Staff Nurse Job Description which I exhibit as Exhibit LT/01 and The NMC Code), assist with attending to her patients' hygiene needs, deliver regular pressure area care and perform routine or repeat observations. There is also an expectation that all staff answer patient's call bells throughout the shift and to attend to any needs the patients may have. While she completed most of her primary duties by administering appropriate medication and documentation accordingly, one patient said she failed to administer prescribed analgesia – even when asked for it directly and another patient said she witnessed her leaving medications unattended in a pot at a patient's bedside and only provided assistance when the other patients in the room informed her that said patient was unable to take them independently, thus prompted her to assist. She failed in other fundamental areas of care such as assisting with hygiene needs and providing basic human comfort.

Reports from Colleague 1 stated that both she and her patients found the registrant to be rude, unhelpful and ignorant to their needs. Colleague 1 stated that even when asked directly by herself or the nurse in charge, the registrant still did not assist in answering call bells or assisting with hygiene needs. She actively encouraged patients to call for another member of staff, despite standing in the same room.'

The panel found that the evidence of Witness 1 to be clear and consistent with her written witness statement. It also found that the evidence of Witness 1 was supported by that of Witness 4.

The panel considered that duty of care towards the patient is a fundamental nursing principle.

The panel found charge 3b proved, on the balance of probabilities.

Charge 3c

‘Between 22 May 2018 and 23 May 2018, demonstrated poor patient care in that you:

c) Ignored call bells from one or more patients when you were available to assist;’

This charge is found proved.

In reaching this decision, the panel noted that charge 3c covers factually the same ground as charge 2b. It took into account the oral evidence and written witness statement of Witness 1 and Witness 4, and exhibits.

The panel relied on its earlier findings of facts as elaborated upon earlier under charge 2b. The panel considered that duty of care towards the patient is a fundamental nursing principle.

The panel found charge 3c proved, on the basis of the evidence before it.

Charge 3d

‘Between 22 May 2018 and 23 May 2018, demonstrated poor patient care in that you:

d) Failed to conduct observations on one or more patients despite being asked by colleagues to do so;’

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence and written witness statement of Witness 1 and Witness 4, and exhibits.

The panel took into account the following from the written witness statement of Witness 1:

‘I checked if she had done the observation but the nurse hadn’t done anything. Some of the patients were scoring high and required observations. For all scoring above the normal score, I informed the staff nurse that observations needed to be repeated whilst I was on a break, as the scores were high, and observations should be done regularly as the patients on the ward scored high. I escalated this by informing the nurse in charge, and also reported it to the ward manage in the morning.’

The panel found the evidence of Witness 1 to be clear, and consistent with her written witness statement.

However, the panel took into account that there are no patient records before it to support the duty contained within this charge. The panel was not satisfied that there was sufficient evidence that the observations were clinically necessary and/or had not been undertaken as required.

On the basis of the very limited evidence before it, the panel was not satisfied, on the balance of probabilities, that the NMC has discharged its burden of proof in relation to this charge.

The panel, therefore, found charge 3d, not proved.

Background

Miss Adebayo entered the NMC registered on 15 September 2011.

The charges arose whilst Miss Adebayo was employed as a registered nurse by an agency called Your World Recruitment Group (‘the agency’) at Royal Shrewsbury Hospital, Singleton Hospital and UCLH.

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 Miss Adebayo's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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, Miss Adebayo's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Butler invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the 2015 Code) and the Code: Professional standards of practice and behaviour for nurses and midwives (2018) ('the 2018 Code') in making its decision.

Ms Butler identified the specific, relevant standards where Miss Adebayo's actions amounted to misconduct.

Ms Butler submitted that when the panel is considering standards relating to medicine management, it must refer to local protocols and instructions exhibited by Witness 2. She submitted that Miss Adebayo's conduct did fall significantly short of the standards expected of a registered nurse in that she has been found to have failed her patients and colleagues in breach of the Codes. She submitted that by failing to observe the obvious urgency of dealing with one patient at a time when administering medication, the process of *"pre-potting"* inserts an unjustified level of risk into this core nursing function.

Ms Butler further submitted that Miss Adebayo's conduct fell significantly short of the standards expected of a Band 5 nurse. Miss Adebayo was supposedly in charge of the 10 patients she was allocated to and required to show leadership and competencies attributable to that grade of qualified nurse. She submitted that a finding that she spent a significant period of time on her mobile telephone demonstrates significant attitudinal problems, poor leadership and a disregard for committing herself to the job at hand. She submitted that Miss Adebayo has been found to have neglected her patients' personal care needs, by refusing to answer call bells and to offer toileting needs when asked.

Referring to the case of *R (on the application of Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin), Ms Butler submitted that the misconduct in this case, is *"sufficiently serious"* that it can be properly described as misconduct by virtue of multiple failings by Miss Adebayo as defined by local policies (medication) and the Code. These failings caused significant distress to her nursing colleague and the suffering of her patients. The patients, it is submitted were sufficiently concerned for their own wellbeing and the protection of others that they reported Miss Adebayo at the first opportunity (the following morning) to Witness 4. The panel will be mindful of Witness 4's observations on the emotional state of Witness 1 who she described as very able, experienced, and not

prone to emotional outbursts. It is submitted that Miss Adebayo's failings and misconduct on the shift on Ward 8 fell significantly below the standard expected of a registered nurse.

The panel did not have any submissions, written or otherwise made, from or on behalf of Miss Adebayo.

Submissions on impairment

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

Ms Butler submitted that in all the circumstances, Miss Adebayo's misconduct has not been remediated; she is silent in response to the concerns despite being given the opportunity to appear at this hearing and explain how she has improved her poor practice. She submitted that a finding of current impairment needs to be proved in order to sufficiently protect the public, maintain the confidence in the NMC as a regulator and uphold the standard of the profession generally. The public interest calls for a finding of impairment to maintain trust and confidence in the profession and its regulator. She further submitted that a well-informed member of the public would be concerned to find that Miss Adebayo was not found to be impaired given the wide-ranging and nature of the charges.

The panel did not have any submissions, written or otherwise made, from or on behalf of Miss Adebayo.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000]

1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

> ***'1. Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> > *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***
> *To achieve this, you must:*
>
> > *2.1 work in partnership with people to make sure you deliver care effectively*
> > *2.3 …*
> >
> > *2.4 …*
> >
> > *2.5 …*

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

To achieve this, you must:

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

8. Work co-operatively

To achieve this, you must:

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

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

To achieve this, you must:

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

20. Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 …

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

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

To achieve this, you must:

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

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 charges 1a, 1b, 2b, 2c, 3b and 3c found proved are serious enough to amount to misconduct. The panel observed that whilst charges 2a and 3a found proved, taken individually do not amount to misconduct, it was of the view, that taken altogether, these charges demonstrate a continuing course of conduct during that shift, which amounts to serious misconduct.

The panel considered that in relation to Charges 1a and 1b, which related to different hospitals and were both escalated by different colleagues, Miss Adebayo's actions have fallen far below the standard expected from a registered nurse. The panel noted that Miss Adebayo is an experienced nurse who should have been competent in medication management and administration, she should have known the correct procedure for administration of medication and had failed to follow the 5 rights of medication administration. Miss Adebayo's actions were unprofessional and could have had significant consequences for the patients and put them at risk of harm.

The panel determined that Miss Adebayo's actions did fall seriously short of the conduct and standards expected of a nurse and therefore amount to misconduct.

Charges 2a, 2b, 2c, 3a, 3b, and 3c all occurred on one night shift and were considered to be a continuing course of conduct throughout that shift. The panel considered that in

relation to these charges Miss Adebayo's actions have fallen far below the standard expected from a registered nurse.

On this shift Miss Adebayo was in charge of 10 patients and the Witness 1 (Health Care Worker) had an additional 5 patients (total 15) to care for. It is clear to the panel that the patients should have received better care and whilst on this occasion there wasn't an adverse incident, there was a real and tangible possibility that this could have occurred. In addition, this lack of care was compounded by Miss Adebayo's attitude towards patients which caused a number of them to become concerned and distressed. It is a reasonable assumption that this will have affected their trust and confidence in the care that they were receiving.

It is clear to the Panel that Witness 1 received little if any support from Miss Adebayo, the impact of this along with her attitude towards Witness 1, colleagues and patients was such that it caused Witness 1 to become distressed at the end of the shift. Miss Adebayo should have provided the proper support and guidance to Witness 1 and acted in accordance with the expectations and professional competencies of a Band 5 Registered Nurse.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Adebayo'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 considered that limbs a, b and c of the above test were engaged by Miss Adebayo's past actions.

The panel finds that Miss Adebayo's patients were put at risk of physical harm and were also caused emotional distress as was Miss Adebayo's colleague. This was a result of Miss Adebayo's misconduct. Miss Adebayo's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel had limited information before it. The panel took into account that 'Statement regarding incident on ward 24' dated 5 December 2018, which Miss Adebayo provided to the Hospital during the course of its internal investigations, and which includes Miss Adebayo's reflections. The panel noted that it has no information before it as to whether Miss Adebayo is working or where she is working, and that it has otherwise, no up to date information from Miss Adebayo.

The panel had regard to the case of *Cohen* and considered that Miss Adebayo's actions were remediable. The panel went on to consider whether Miss Adebayo remained liable to act in a way to put patients at risk of harm, to bring the profession into disrepute and to breach fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

Whilst the panel concluded that the misconduct in this case is capable of being remediated, the panel has no evidence before it of whether Miss Adebayo's has taken steps, if any, to address her misconduct and strengthen her practice. The panel, therefore, found that there is a risk of repetition. The panel 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 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 Miss Adebayo's fitness to practise impaired on the grounds of public interest.

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

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Misconduct which put patients at risk of suffering harm
- Actual upset and distress caused to patients and a colleague
- Apparent lack of insight into failings

The panel did not find any mitigating features in terms of insight and remediation.

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 public protection issues identified, an order that does not restrict Miss Adebayo'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 Miss Adebayo's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified and risk of repetition. 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 Miss Adebayo's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Potential 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 had regard to the fact that these incidents happened a long time ago and that, other than these incidents, Miss Adebayo had an unblemished career as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, Miss Adebayo should be able to return to practise as a nurse. Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel noted that Miss Adebayo had to date, failed to fully comply with previous orders and engage with the process, although as far as the NMC were aware, she had not been practising as a registered nurse since April 2020. It was not clear if this was due the pandemic, [PRIVATE] the challenges of securing agency work with restrictions on her practice, or a general unwillingness to engage at that stage. The panel decided it was fair to provide her with this opportunity to engage, whilst at the same time through a conditions of practice order provide the requisite protection for the public.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Miss Adebayo's case. A conditions of practice order would be sufficient enough to protect the public and to enable Miss Adebayo to strengthen her practice.

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 not be the nurse in charge of the shift.

2. You must not manage or administer any medication without direct supervision by a registered nurse.

3. You must keep a personal development log to address how you are strengthening your practice in relation to:
    - The management and the administration of medication including, where appropriate electronic systems
    - Treating patients with dignity and respect
    - Working with colleagues to provide effective care
    - Communication with colleagues, including handover

    The log must:
    - Contain the dates that you carried out these tasks
    - Show where you are working
    - Be signed by your supervisor
    - Contain feedback from your supervisor on how you carried the tasks out

You must send your case officer a copy of the log every three months

4. You must prepare and submit a reflective piece that addresses the concerns in the charges and what you have done to strengthen your practice and minimise the risk of repetition

5. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from either your line manager, mentor, or supervisor.

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

7. 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.

8. 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

9. 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.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.

c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months.

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

Any future panel reviewing this case would be assisted by:

- Miss Adebayo's engagement/attendance at a future hearing
- Evidence of keeping up to date with nursing practice
- Character references and testimonials from any paid or unpaid work

This will be confirmed to Miss Adebayo in writing.

Interim order

As the conditions of practice 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 Miss Adebayo's own interests until the conditions of practice 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 Ms Butler. She submitted that an 18-month interim conditions of practice order should continue on the same terms as the

previous order. She submitted that public confidence in the profession would be affected if Miss Adebayo were allowed to practise without restriction during the appeal period.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public, in the public interest, and also in Miss Adebayo's own interests. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.