Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday, 1 – Monday, 26 February 2024
Tuesday, 2 – Friday, 5 April 2024

Virtual Hearing

Name of Registrant:	**Bukola Ayo-Adesanya**
NMC PIN:	16C0279E
Part(s) of the register:	Registered Nurse – Sub part 1 Mental Health Nursing – 14 May 2016
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	Museji Ahmed Takolia CBE (Chair, lay member) Richard Weydert-Jacquard (Registrant member) Gill Mullen (Lay member)
Legal Assessor:	John Bromley-Davenport KC Fiona Moore (2-5 April 2024)
Hearings Coordinator:	Rim Zambour (1-9 February 2024) Clara Federizo (12-26 February 2024) Rene Aktar (2-5 April 2024)
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter
Miss Ayo-Adesanya:	Present and unrepresented (1-5 February 2024)
Facts proved:	Charges 2, 3, 8, 14, 15, 20(a-c), 21, 22(a-b), 23, 24, 25, 26, 27(a-b), 28, 29, 30, 31, 32, 34, 35.1, 35.2, 35.2.1, 35.2.2, 35.2.3, 35.2.5, 35.2.6, 36, 37, 40(a-c), 41, 42(a-b) and 43
Facts not proved:	Charges 1.1, 1.2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 16, 17, 18, 19, 33, 35.2.4, 38 and 39

Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on application for adjournment

At the outset of the hearing, you made an application for adjournment on two grounds. The first ground was to allow you to find legal representation as you had previously been represented by the Royal College of Nursing (RCN) [PRIVATE]. The second ground was in relation to [PRIVATE]. You stated that [PRIVATE] to proceed and as such, [PRIVATE].

You stated that it has been seven years since the alleged incidents and that you are equally keen for this hearing to be heard, but that [PRIVATE] if the panel decide not to grant the adjournment, and you do not know whether you will attend.

Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), submitted to the panel that you had contacted your Case Coordinator on 25 January 2024 requesting that the hearing be postponed as you wanted to find representation. He stated that the RCN had informed the NMC on 3 January 2024 that they were no longer acting for you. Further, that since 3 January 2024, the NMC had made multiple attempts to contact you to confirm whether you would be attending but received no response until your phone call on 25 January 2024. Mr Malik submitted that the NMC has therefore made all reasonable efforts to get you to engage with no response until 25 January 2024.

Mr Malik submitted that you have had ample time to seek alternative legal representation and asked the panel to consider the length and complexity of this case along with the efforts undertaken to secure witness evidence. He reminded the panel that there are 20 witnesses listed for this hearing, and that some of them are vulnerable and will receive support from the Public Support Service (PSS) team. Mr Malik submitted that these witnesses [PRIVATE] the dates are changed. Mr Malik also informed the panel that one of the witnesses was reluctant to give evidence due to the length of time that has passed, but they have finally agreed, and this may affect them giving evidence at a later stage.

Mr Malik informed the panel that the NMC contacted you in relation to the Case Management Form (CMF) on 12 October 2023 and neither you nor your representative had responded. Further, that there have been two applications to the High Court to extend your current interim suspension order and that further delays to your case being heard may well necessitate further applications to the High Court which in turn, would have a significantly adverse impact upon all parties involved in the expeditious review of this case.

Mr Malik referred to the case of *General Medical Council v Adeogba* [2016] WLR(D) 156 and submitted that it would be extremely unfair to the NMC if this adjournment application were granted.

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

The panel appreciated the complexity of the case and the amount of time that has passed since the alleged concerns. It however accepted the arguments put to it by the NMC and has determined that you have had sufficient opportunity to secure legal representation since the RCN stopped acting for you. The panel also noted that the NMC has made multiple attempts to contact you, and that you were aware of the dates of the hearing.

The panel was made aware [PRIVATE]. It noted [PRIVATE]. It is important that you are able to participate. However, whilst the panel determined that there is a strong public interest in proceeding with the hearing expeditiously, it would be fair, on balance, to give you further time to seek legal representation and satisfy itself on the question about your ability to continue to engage with the proceedings as they move forward.

The panel therefore made the following proposals for you to consider:

1. That it would assist the panel [PRIVATE]. The panel decided to adjourn the hearing until 9:30am on day 3, namely 5 February 2024, to secure this information.
2. The panel decided to also allow you until 9:30am on 5 February 2024 to seek legal representation.
3. In any event, it may be helpful for you to be supported during the hearing through the NMC's services [PRIVATE].

The panel therefore adjourned this hearing until the morning of 5 February 2024.

Decision and reasons on application for adjournment on day three

You attended the hearing on day three, namely 5 February 2024, and informed the panel that you had not been able to get legal representation because of the short space of time, with Friday 4 February 2024 being the only working day available to you. You said that most of the legal representatives you had spoken to already had prior engagements and stated that they needed time to go through the significant amount of information in the bundles.

You informed the panel [PRIVATE]. They had told you that you would need to send your request for a letter in writing which would take a number of working days to review.

You told the panel that [PRIVATE], if your request for an adjournment is not accepted then you will be left with no other choice than to request a voluntary removal from the NMC register.

Mr Malik informed the panel that issues had already arisen in relation to witnesses as there are over 20 in this case. He respectfully asked the panel to proceed as it would be very difficult for the NMC to rearrange and reschedule witnesses. He submitted that you have had over one month to seek legal representation since the

RCN ceased to act for you on 3 January 2024. He also submitted that you did not engage with the NMC when you had the opportunity to do so.

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

The panel determined that, its earlier proposals were made to provide some consideration of your circumstances and personal welfare and that, given this case has already been running for seven years, it would cause a great deal of unfairness to the NMC and in particular, to the witnesses, if the panel adjourned today. It also considered that you had not been able to [PRIVATE] and had not provided any indication as to the length of time the proposed adjournment would be for. Further, that you were represented by the RCN and had the opportunity to prepare for the hearing having known about it since October 2023.

The panel therefore declined your application to adjourn the hearing.

Having heard that you may not attend the hearing if the hearing is not adjourned, the panel went on to decide whether it should proceed in your absence.

Decision and reasons on proceeding in your absence

The panel next considered whether it should proceed in your absence. It had regard to Rule 21 and heard the submissions of Mr Malik who invited the panel to continue in your absence should you choose not to attend.

Mr Malik relied on his submissions in relation to the adjournment application in that they also relate to proceeding in absence.

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 your absence should you choose to no longer attend the hearing. In reaching this decision, the panel has considered the submissions of Mr Malik, your representations 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:

- The charges relate to events that occurred seven years ago;
- You have had sufficient opportunity to prepare for this hearing and engage with the proceedings;
- There is now a backlog of four witnesses who have been scheduled to give live evidence so far, with a total of twenty due to attend;
- Not proceeding will inconvenience all the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- [PRIVATE]; and
- There is a strong public interest in the expeditious disposal of the case.

The panel acknowledges that there is some disadvantage to you in proceeding in your absence. The panel is mindful of the fact that evidence upon which the NMC relies will have been sent to you at your registered address, you have made no response to the allegations. Your absence does mean that you may not be able to challenge the evidence relied upon by the NMC in person and may not be able to give evidence on your 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.

The panel will continue to keep you informed and invite written submissions from you. Should you decide to attend, the panel would consent to your continuing engagement with the proceedings.

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

Decision and reasons to amend the charge

In reviewing the evidence before it during the panel's deliberations on facts, the panel amended the wording of charge 23 to correct the date, specifically the month. The amendment is as follows:

> *"That you, a registered nurse,*
> *…*
> *23. On 29 ~~October~~ **September** 2017 claimed to have attended Breakaway Training when you did not.*
> *…*
> *And in light of the above, your fitness to practise is impaired by reason of your misconduct."*

The panel noted that this was a simple typographical error which required correction and making such a correction would not alter the essence of the alleged charge.

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

The panel was of the view that such amendments were in the interests of justice. The panel was satisfied that there would be no prejudice to Miss Ayo-Adesanya, and no injustice would be caused to either party by the corrections being allowed. It was therefore appropriate to allow the amendments to ensure clarity and accuracy of the alleged charges, and which reflects the evidence before it.

Details of charge (as amended)

That you a registered nurse,

<u>On 1 May 2017, whilst working for Huntercombe Hospital:</u>

1. Threatened one or more of the following patients with seclusion without clinical justification:

   1.1 Patient A
   1.2 Patient B

2. Gave the impression to Patient B that you were calling the police when in fact you were not.

3. Your actions at charge 2 intended to cause Patient B fear/alarm and/or distress.

4. Restrained Patient C in an inappropriate manner.

5. Left a curtain hanging in Patient C's room despite being aware of the Doctor's instructions to strip the room.

6. On being told by Colleague 1 that Patient C had pulled her curtain down, took no action.

7. Told Patient B that she would be receiving an additional IM injection which was not appropriate.

8. Attempted to administer the IM injection to Patient B in her bedroom which was not appropriate.

9. Administered an IM injection of Lorazepam to Patient B at approximately 23:46 without clinical justification.

10. Did not give Patient B the option of receiving Lorazepam orally.

11. After administering the IM injection to Patient B at 23:46 did not take/ or ensure that the patients vital signs were monitored /or observed.

12. Administered an IM injection to Patient B at approximately 2.20hrs without clinical justification.

13. Did not give Patient B the option of receiving medication orally.

14. Threatened an unknown patient with an IM injection if they did not go to their room.

15. On one or more occasions pointed your finger at one or more patients which was inappropriate in that it is an aggressive way of communicating.

16. Were not visibly present to patients.

17. On witnessing Patient B being restrained inappropriately, did not intervene as manager.

18. In relation to Patient A did not ensure that appropriate de-escalation techniques were utilised before the patient was physically restrained.

19. Did not provide oversight or management regarding the restraint of Patient A.

Whilst working for Cygnet Hospital, Godden Green:

20. On one or more of the following occasions claimed that you had worked your full shift when you had not:

    a. 20 September 2017.
    b. 4 October 2017.
    c. 5 October 2017.

21. Your actions at charge 20a, and/or b and/or c were dishonest in that you sought to create the impression that you had worked your full shift when you knew that you had not.

22. On one or more of the following occasions claimed that you had attended your shift when you had not:

    a. 22 September 2017.
    b. 30 September 2017.

    Your actions at charge 22a and/or b were dishonest in that you sought to create the impression that you had attended work when you knew that you had not.

23. On 29 September 2017 claimed to have attended Breakaway Training when you did not.

24. Your actions at charge 23 were dishonest in that you sought to create the impression that you had attended the training when you that you had not.

25. On 5 October 2017 continued to use your mobile phone despite being aware that you were not supposed to use it.

26. On 6 October 2017 did not carry out patient observations which you were assigned to do between 11pm to midnight.

27. On one or more of the following occasions left one or more patients to dispense their medication without supervision:

    a. 2 September 2017.
    b. 21 September 2017.

28. On one or more occasion slept whilst on duty

Whilst working for Winchester House Care Home:

29. On 4 November 2020 on being advised by Colleague 2 that a resident may need some help with washing and dressing stated *'I don't do personal care'* or words to that effect.

30. Made the comment as detailed in charge 29 within earshot of other residents at the home.

31. On 4 November 2020 left your shift early without authorisation.

32. On one or more occasion used your mobile phone whilst on duty.

33. Slept when you were supposed to be participating in mandatory training.

34. On one or more occasions slept whilst you were on duty.

35. On or around 18 April 2020, on becoming aware that Patient F was on the floor:

35.1 did not assist colleague 3 in getting them off the floor.

35.2 did not complete one or more of the following checks:

35.2.1 initial observation;
35.2.2 neurological observation;
35.2.3 assess them for bruising or fractures;
35.2.4 checked their surroundings for safety;
35.2.5 complete an accident and incident report form;
35.2.6 devise a plan to prevent future occurrences.

36. On one or more occasions refused to assist Colleague 3 and/or Colleague 4 with the personal care and /or general care of one or more residents.

37. On an unknown date in June 2020 did not help Colleague 4 with an incident with Patient E.

38. Did not disclose to Winchester House Care Home that you were under investigation by the NMC.

39. Your actions at charge 38 were dishonest in that you sought to conceal the fact that you were under investigation by the NMC in order to gain employment.

40. Provided Individual 3's details as a referee, stating that he was your manager when applying to one or more of the following organisations:

a. Barchester healthcare;
b. Medicure Professionals;
c. Medics Pro.

41. Your actions at any or all of charge 40 was dishonest in that you stated that Individual 3 had been your line manager when you knew that they were not.

42. Provided Individual 4's details as a referee, stating that they were your line manager when applying to one or more of the following organisations:

    a. Barchester;
    b. Medicure Professionals.

43. Your actions at any or all of charge 42 was dishonest in that you stated that Individual 4 was your line manager when you knew that they were not.

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

Background

The charges arose whilst Miss Ayo-Adesanya was employed as a Registered Mental Health Nurse. She qualified and first joined the NMC Register in May 2016. The allegations against her are wide-ranging and involve three different care settings.

Miss Ayo-Adesanya was referred to the NMC by Witness 4, the Head of Quality and Governance at Huntercombe Hospital Stafford (Huntercombe), following multiple alleged incidents on 1 May 2017. Further incidents subsequently came to light at other care settings where she worked; namely Cygnet Godden Green Hospital (Godden Green) and Winchester House Care Home (Winchester). Consequently, additional areas of alleged regulatory concerns were investigated in relation to her nursing practice.

The allegations against Miss Ayo-Adesanya are multiple and wide-ranging in nature. On 1 May 2017, it is alleged that several incidents occurred during a night shift on the Psychiatric Intensive Care Unit (PICU) at Huntercombe. These gave rise to a

range of regulatory concerns regarding Miss Ayo-Adesanya's professional practice including her failure to treat patients with dignity and respect. The allegations relate both to her attitude to colleagues and patients as well as the safety of her nursing practice.

Miss Ayo-Adesanya previously worked for Cygnet in June 2016. In June 2017, following her suspension from Huntercombe. She returned to work for Cygnet as a registered mental health nurse at Cygnet Godden Green, Saltwood Ward – a low security male forensic psychiatric ward. Whilst working at Godden Green, Miss Ayo-Adesanya is alleged to have acted unprofessionally and dishonestly. Several of the allegations again concerns the safety of her clinical practice.

On 12 June 2019, Miss Ayo-Adesanya applied to work at Winchester House Care Home. During the application process, she is alleged to have acted dishonestly including providing details of two referees, both of whom she said were her line managers, when she allegedly knew they were not. Further, she allegedly did not disclose to Winchester that she was under investigation by the NMC and sought to conceal this in order to gain employment.

Miss Ayo-Adesanya started employment as a Staff Nurse at Winchester in July 2019. It is alleged that in November 2020, Miss Ayo-Adesanya refused to provide personal care to the residents and left her shift abruptly without authorisation. Here too, the allegations against her are wide-ranging. These alleged that she:

- Refused to assist colleagues;
- Left a patient on the floor and failed to complete the relevant checks/observations/assessments/accident and incident report form/plan to prevent future occurrences;
- Used her mobile phone whilst dispensing medication; and
- Slept on duty and/or when expected to participate in training.

Consequently, Miss Ayo-Adesanya was suspended from her position at Winchester.

On 16 November 2020, Miss Ayo-Adesanya attended an Investigatory Meeting with Home Manager at Winchester Care Home, Witness 14, where Miss Ayo-Adesanya denied the concerns. Subsequently, Miss Ayo-Adesanya resigned from her post in March 2021.

All the above allegations are disputed by Miss Ayo-Adesanya.

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 Mr Malik on behalf of the NMC, and Miss Ayo-Adesanya's written responses to the allegations in 2019 and her reflections in 2021.

The panel has drawn no adverse inference from the non-attendance of Ms Ayo-Adesanya.

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

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

- Witness 1: At the time, was the Risk Management Co-ordinator managing the Local Authority Designated Officers at Huntercombe;

- Witness 2: Hospital Director for Huntercombe Hospital;
- Witness 3: At the time, was a Quality Governance Manager at Huntercombe;
- Witness 4: Head of Quality and Governance, Deputy Hospital Director for Huntercombe and the person who made the initial referral;
- Witness 5: At the time, was an Acting Consultant Psychiatrist at Huntercombe;
- Witness 6: At the time, was a Staff Nurse at Saltwood Ward at Cygnet Hospital Godden Green;
- Witness 7: At the time, was the Ward Manager on Saltwood Ward at Cygnet Godden Green;
- Witness 8 / Colleague 1: At the time, was a Healthcare Support Worker on the PICU at Huntercombe;
- Witness 9: At the time, was a Healthcare Assistant on Saltwood Ward at Cygnet Maidstone;

- Witness 10: At the time, was a Mental Health Nurse on the PICU at Huntercombe;
- Witness 11: Unit Manager on Marconi at Winchester House Care Home;
- Witness 12 / Colleague 2: Care Practitioner and Unit Manager at Winchester House Care Home;
- Witness 13: Senior Nurse at Winchester House Care Home;
- Witness 14: General Registered Manager at Winchester House Care Home;
- Witness 15 / Colleague 3: At the time, was a Healthcare Assistant at Winchester House Care Home;
- Witness 16 / Colleague 4: At the time, was a Healthcare Assistant at Winchester House Care Home;
- Witness 17: General Manager at Cygnet Hospital Beckton;
- Witness 18: Recruitment Consultant at MH Hunter Gatherer Group (the Agency);

- Witness 19: At the time, was the Interim Unit Manager of the Eating Disorder Unit at Huntercombe;

- Witness 20: People Relations Manager for East London NHS Foundation Trust (ELFT).

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Miss Ayo-Adesanya.

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

On 1 May 2017, whilst working for Huntercombe Hospital

Huntercombe is a Child and Adolescent Mental Health facility, consisting of an eating disorder service (Wedgewood Ward), a general acute unit (Thorneycroft Ward), and a PICU (Hartley Ward). The PICU was closed temporarily due to a CQC inspection that placed the hospital under special measures. The PICU was reopened around April 2017.

The PICU specializes in treating high-acuity cases of young people detained under Section 3 of the Mental Health Act, dealing with issues such as suicidal ideation, depression, anxiety, Post Traumatic Stress Disorder, and autism. The facility provides a secure setting with anti-ligature fixtures, a de-escalation room, and a seclusion room. Patients are typically aged between 12 and 17, often presenting with complex mental health concerns.

Upon reopening, the PICU underwent careful monitoring and a gradual admission process and did not reach full capacity immediately. There was reliance on agency

staff initially, with some substantive staff employed by The Huntercombe Group. Despite the presence of agency staff, no major concerns were reported during the reopening period.

The panel heard evidence to suggest that Miss Ayo-Adesanya was being targeted by a group of patients who disliked the way she conducted herself. There was a general consensus, based on the witness evidence and Miss Ayo-Adesanya, that on the particular nightshift of 1 May 2017, the Ward became *[PRIVATE]* according to Miss Ayo-Adesanya and that *"all hell [was] breaking loose"* according to Witness 2.

The panel recognised that several witnesses heavily relied on CCTV evidence without sound. It noted that some footage was viewed by witnesses and was unavailable to the panel because it had subsequently been deleted. Moreover, some activity inevitably will have taken place away from the camera. The panel did not directly view the footage at Huntercombe. The panel was of the view that some of the evidence relied on inference from video footage viewed without sound and that this resulted in some bold assertions and conclusions from witnesses in their testimony. Nevertheless, the panel was mindful to balance this cautiously with the fact that several witnesses, being senior professionals, were credible, and their professional judgments could be relied on to assist the panel.

The panel considered written responses from Miss Ayo-Adesanya in her Registrant bundle, acknowledging that as she was absent from the hearing, she did not give evidence under oath or affirmation and therefore the panel was unable to subject her to examination. Thus, the panel was minded to attach the appropriate weight to her contribution. Further, the panel bore in mind at all times that the burden of proof was on the NMC. It resolved to examine the twenty witnesses thoroughly to ensure fairness to Miss Ayo-Adesanya.

Charge 1 (in its entirety)

"That you, a registered nurse,

On 1 May 2017, whilst working for Huntercombe Hospital

1. *Threatened one or more of the following patients with seclusion without clinical justification:*

    1.1 Patient A
    1.2 Patient B"

This charge, in its entirety, is found NOT proved.

In reaching this decision, the panel took into account all the documentary and witness evidence before it. The panel considered the charges individually at first, and then collectively.

The panel considered the written evidence of Colleague 1 in relation to this charge:

> *"11. After Buki walked out of the therapy room I heard her say to [Patient B] 'You need to go to your room now or you'll be next.' HCA…also heard her say this. I was angry that Buki had made that comment to a patient, particularly after all the extra upset she had caused. Once it was safe to leave the therapy room, I went straight to the nursing office where Buki and [Witness 10] were, and I said to Buki that seclusions and IMs must not be used as a threat. She said "What do you mean?" and I said that on three separate occasions that shift I had heard her threaten patients with seclusions or IMs…*
> *…*
> *17. Throughout the shift Buki had made threats of seclusion to [Patient A] and [Patient B]. [Patient B] came to me at one point and said Buki had threatened to put her in seclusion…"*

In light of Colleague 1's description of the events, the panel began with its consideration of the charges with the dictionary definition of the word 'threatened':

“State one's intention to take hostile action (against someone) in retribution for something done or not done”

The panel noted that this use of language was strong and emotive in nature. It noted that Colleague 1's testimony lacked specific details regarding the timing of the 'threatening’ incident or reference to any circumstances that might have led to it.

The panel went on to determine whether the actions described by Colleague 1 as threats to place the patients into seclusion were made without clinical justification. The panel turned to ‘The National Institute for Health and Care Excellence (NICE)’ guidelines in respect of short-term violence and aggression. Specifically, section *‘1.4 Using restrictive interventions in inpatient psychiatric settings’,* which provided clarity to the definition of seclusion and when it is appropriate to implement restrictive interventions:

“only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken”

The panel also took into consideration the patients’ care plans.

The panel had regard to Miss Ayo-Adesanya’s written responses and reflections in relation to this allegation:

“I would not at any point threaten a patient with the use of IM injection and/or seclusion as alleged…I take pride with been very respectful and upholding people’s human rights and dignity and…will never use my role/power to threaten anyone…On the night of the incident on the 1st May 2017, I had sought the right support and advice to help manage the series of events that had started to build up hence resulting to the administration of IM medication as a last resort…”

The panel also considered Miss Ayo-Adesanya's statement summary of the incident, in an email dated 4 May 2017:

> *"…Following T/C to on-call doctor informing him of the situation on the ward at the time, he advised we administer 25mg Promethazine intramuscularly after several attempts made to offer PRN orally was declined by [Patient B] further suggested a plan for seclusion (as a last resort) if risk behaviour escalates and becomes unmanageable which may affect other patient's safety. This was clearly communicated to [Patient B] (involving the patient in their own care) and in the presence of other staff members.*
>
> *[Colleague 1] appeared displeased with the plan, derogatorily questioned why the patient needed to be IM'd and possibly secluded. After been informed, [Colleague 1] volunteered in the presence of other staffs that she did not want to jeopardise her friendship with the patient hence is not going to be part of the team's plan..."*

The panel recognised that Miss Ayo-Adesanya's account was consistent with the account recorded at the Investigatory Meeting on 10 May 2017:

> *"…I informed [Dr / Witness 5] she [Patient B] was escalating rather than calming down. She was banging on the nursing office window. [Dr / Witness 5] prescribed 25mg promethazine. I informed him that in her care plan it said that if her behaviour escalated to consider seclusion. Doctor agreed with this so I informed the team of this plan and said I would need help to hold her…and [Colleague 1] did not want to jeopardise her friendship."*

The panel considered Witness 10's evidence, noting that he was also present at the time of the events. It found that there is no mention in Witness 10's evidence that Miss Ayo-Adesanya had 'threatened' patients with seclusion. Other than Colleague 1's testimony, the panel had no other supportive or corroborative evidence that it could rely on. It determined that Colleague 1's evidence lacked detail about the

context which gave rise to the events and/or actions taken by Miss Ayo-Adesanya, in order to determine whether such actions were clinically justified.

The panel accepted that Miss Ayo-Adesanya's account was consistent in her written response that she used seclusion as a *"last resort"* restrictive measure in light of the patients' behaviour and with the doctor's advice, as opposed to a deliberate act undertaken in a manner so as to take hostile action against them in retribution as suggested in the definition of the word 'threaten'. It recognised that Miss Ayo-Adesanya's assertion that she *"informed the doctor"* and that the *"doctor agreed"* with the actions taken was partially supported by Witness 5's testimony. He stated:

> *"I cannot remember this specific incident…If what is documented is accurate e.g., Patient B threatening staff and throwing sand that she claimed to have urinated in on staff, then I believe that their administration was clinically justified."*

The panel was not satisfied that there was sufficient evidence to conclude that, on the balance of probabilities, Miss Ayo-Adesanya threatened Patients A and B with seclusion without clinical justification. It therefore found that the NMC had not discharged its burden of proof in relation to this charge.

Accordingly, the panel finds charge 1, in its entirety, not proved.

Charge 2

> *"2. Gave the impression to Patient B that you were calling the police when in fact you were not."*

This charge is found proved.

In reaching this decision, the panel took into account all the documentary and witness evidence before it.

The panel had regard to the witness statement of Colleague 1:

> *"7. At around 11pm I had been on observations for a patient down the corridor, I had the door shut so I couldn't see what was happening on the rest of the Ward. While I was there I could hear that the sand had been thrown over Buki and went to assist. Patient B asked her if she was going to phone the police, and Buki said "It's up to me". Patient B asked again "But are you phoning the police?", and Buki just walked off without even looking at her. Buki then went into the office and picked up the phone and stared at Patient B. Patient B said to me "She's ringing the police!" I said "You can't make assumptions, you don't know who she's ringing."*

The panel also had regard to Miss Ayo-Adesanya's statement in relation to this charge taken during the Investigatory Meeting on 10 May 2017:

> *'I kept saying that this was not acceptable behaviour and that I may need to press charges. Patient B said to me "This is petty if you want to press charges for someone pouring sand on you".'*

The panel found Colleague 1's oral evidence to be consistent with her witness statement. In response to Mr Malik during her oral evidence, Colleague 1 stated that Miss Ayo-Adesanya had *'like a good mind'* to call the police and *"…went into the office, she went straight to the phone while staring at the patient and picked up the phone, put it to her ear, and then sort of started talking while staring at the patient."*

The panel also had regard to Witness 10's witness statement:

> *"…Patient B took a pot of sand out of her pocket and threw it towards Buki in the office. Buki the came out of the office and told Patient B she was not here to be abused; she said Patient B has assaulted her and she was going to call the police. Buki went back into the office and picked up the phone; she was*

not actually phoning the police in my option but Patient B saw this through the office window and believed she was."

The panel found that Witness 10's evidence was consistent with his oral evidence and corroborative of Colleague 1's testimony, as he confirmed in oral evidence that Miss Ayo-Adesanya *"did take the phone"* and that *"[he] didn't believe that she was calling the police, but she was just making an impression that she was calling the police"*.

The panel noted that neither Colleague 1 or Witness 10 were inside the office with Miss Ayo-Adesanya to discern whether she called the police or not, however, it accepted that there was no evidence that the police attended or any record of a phone call to police presented before it. It heard consistent and corroborative evidence that Miss Ayo-Adesanya went back into the office and picked up a phone after saying that she would call the police, and that she could be seen, by both witnesses and Patient B, through the glass window. Therefore, on the balance of probabilities, the panel was satisfied that it was more likely than not that Miss Ayo-Adesanya gave the impression to Patient B that she was calling the police when in fact she was not.

Accordingly, the panel finds charge 2 proved.

Charge 3

"3. Your actions at charge 2 intended to cause Patient B fear / alarm and/or distress."

This charge is found proved.

The panel noted the implicit connection between charge 2 and this charge. However, determining charge 2 to be proven did not imply an automatic finding for this charge.

The panel had regard to the written statements of Colleague 1 and Witness 10 as outlined in the charge above and found them to be consistent with their oral evidence. Colleague 1 confirmed in her oral evidence that *"Patient B was upset…she was already in distress and made her even worse"*, so she attempted to *"calm her down".* Witness 10 echoed this in his oral evidence, as he *"tried to reassure*" Patient B because *"she became very worried that she's going to be reported to the police".*

The panel was satisfied that, on the balance of probabilities, it was more likely than not that Miss Ayo-Adesanya's actions at charge 2 were intended to cause Patient B fear, alarm or distress. It could not find any other explanation to rationalise Miss Ayo-Adesanya's actions, which were provocative in nature, particularly given the vulnerability of Patient B as a mental health patient with anxiety.

Accordingly, the panel finds charge 3 proved.

Charge 4

> *"4. Restrained Patient C in an inappropriate manner."*

This charge is found NOT proved.

The panel had regard to Colleague 1's witness statement in relation to this charge:

> *"8. …I saw Patient C lying on her back across some chairs, and a staff member was lying on top of her. Me and another HCA…went to help as we needed to get the patient into a safe position on the floor to restrain her. [The HCA] and I took hold of a leg each initially; however usually one person has both the patient's legs during a restraint. Patient C was lying in a T position with her arms out straight, they should be by her sides so this was not acceptable for restraint…When I went round to her left arm I realised the person restraining her was Buki. I wasn't sure whether Patient C had pulled her down initially or how she had ended up in that position lying on top of the*

patient. Buki moved off when I took the left arm and Patient C stated going into a flashback. I know that restraint aggravates this patient during flashbacks, so I asked if everyone was comfortable to stop the restraint and we did."

The panel noted that whilst Colleague 1 does not appear to have witnessed the lead up to the events, Colleague 1's evidence was found to be consistent with her written statement.

The panel also had regard to Witness 10's written statement in relation to these events, which provided context as to the lack of restraint trained staff on the Ward that night. In his evidence, Witness 10 contradicts Colleague 1's statement as he states that:

"…Patient C began attacking Buki…when support finally arrived they had to get Buki off the floor where Patient C was on top of her. Patient C took Buki's wig off and threw it to Patient B so they started throwing it around and it took us a bit of time to get it back…".

The panel also noted that there was evidence from other witnesses of more than one incident that required restraining patients on that night.

The panel having noted discrepancies in the accounts of the two witnesses and concluded that it could not properly rely on the evidence before it to find this charge proved. The panel preferred the evidence of Witness 10 as it detailed the events that led to the incident, and it appeared that Colleague 1 did not witness what took place before she came to the assistance of her colleague.

The panel was not satisfied that there was sufficient evidence before it that Miss Ayo-Adesanya had restrained Patient C in an inappropriate manner, as the witness evidence available to the panel about how Miss Ayo-Adesanya and Patient C were positioned was inconclusive. It also could not discern whether any restraint

measures undertaken by Miss Ayo-Adesanya were performed in an 'inappropriate' manner as there was evidence from Witness 10 to satisfy the panel that restraint may have been necessary in light of *"Patient C attacking Buki".*

Accordingly, the panel finds charge 4 not proved.

Charge 5

> *"5. Left a curtain hanging in Patient C's room despite being aware of the Doctors instructions to strip the room."*

This charge is found NOT proved.

The panel had regard to the witness evidence of Colleague 1:

> *"13. I went back to the office to discuss the situation. [Witness 10] said the incident with the curtain had been reported to the doctor and he had advised the room be stripped. I asked why one curtain was still hanging, and advised that Patient C had always slept on floor and the room was cold. [Witness 10] and Buki said we had to follow the doctor's instructions and she would have to sleep as she was."*

The panel accepted Colleague 1's evidence that a curtain was left hanging despite instructions to strip the room. It noted that both Miss Ayo-Adesanya and Witness 10 were informed and aware of the doctor's instructions. It appeared to be unclear however, which nurse had accepted responsibility to ensure that the instruction was carried out as both Miss Ayo-Adesanya and Witness 10 were on duty with Patient C.

The panel had regard to the witness statement of Witness 10, another nurse on duty during the night shift:

"…during hourly observational checks Patient C was found attempting to tie a ligature with a pair of leggings. We then noted that all her belonging were still in her room including further items that may pose a risk, so the room had to be stripped. Patient C later attempted ligature using the curtains. Curtains had to be removed and all items which were deemed a risk to her."

The panel noted that in his evidence, Witness 10 speaks of the issues that relate to this charge when he confirmed that there were instructions from the doctor to strip the room, including the curtains. However, the panel is satisfied that Witness 10 does not specify whether this was the sole responsibility of Miss Ayo-Adesanya or a shared duty between them.

The panel had regard to further documentary evidence including the relevant Datix incident reports and the [PRIVATE] care plan for Patient C' dated 1 May 2017. The panel noted that the 'intervention details' section of Patient C's care plan stated that *"she is not allowed to have anything that is a possible ligature [PRIVATE]"*. As it is written on Patient C's care plan, the panel determined that it was reasonable to expect that Miss Ayo-Adesanya would be aware of this. However, the panel noted that there was another nurse on duty, Witness 10, who was also responsible for the care of Patient C. The panel determined that he was equally expected to be aware of this.

The panel was not satisfied that the NMC had discharged the burden of proof. The panel was not persuaded that it was Miss Ayo-Adesanya's sole duty on the night to strip the room as instructed. The evidence does not sufficiently demonstrate, on the balance of probabilities, that Miss Ayo-Adesanya left the curtains hanging despite being aware of the doctor's instructions or that she was the nurse with the sole responsibility to ensure that this was carried out.

Accordingly, the panel finds charge 5 not proved.

Charge 6

"6. On being told by Colleague 1 that Patient C had pulled her curtain down, took no action."

This charge is found NOT proved.

The panel had regard to the statement of Colleague 1, which outlined that:

> *"…during general observations…I noticed that Patient C had pulled her remaining curtain down and was lying on it on the floor with her dressing gown over her. I went to the office to report this and Buki said I should have reported it immediately due to risks of threads in the curtain…As far as I know no action was taken and Patient C was left asleep on the curtain."*

The panel noted that in Colleague 1's evidence she confirmed that Miss Ayo-Adesanya provided a response after telling her that Patient C pulled her curtain down. It considered that Miss Ayo-Adesanya's response could be interpreted as a direction that Colleague 1 is to report it to the nurse in charge or was at least acknowledgement on her part that she would handle it later on.

The panel heard evidence from multiple witness accounts that suggested that Witness 10 was formally designated as the nurse in charge of the PICU on this nightshift. The panel accepted however that Miss Ayo-Adesanya, through her earlier actions, appeared to have assumed the responsibility as she was more experienced than Witness 10 having previously worked on a similar unit. The panel considered that it was reasonable for Witness 10 to believe that directions and instructions would be led under Miss Ayo-Adesanya's supervision rather than his.

The panel found the evidence to be limited and unclear as to the chronology and whether Miss Ayo-Adesanya had taken action or not. The panel had evidence that Witness 10 removed the curtains from Patient C's room. Thus, it was possible that Miss Ayo-Adesanya instructed and/or communicated the information to Witness 10. The panel found there to be insufficient evidence to find, on the balance of

probabilities, that Miss Ayo-Adesanya took no action. It determined that the NMC had not discharged its burden of proof in relation to this charge.

Accordingly, the panel finds charge 6 not proved.

Charge 7

> *"7. Told Patient B that she would be receiving an additional IM injection which was not appropriate."*

This charge is found NOT proved.

The panel approached this charge with a particular focus on the word 'told' and therefore first discussed the question as to whether Miss Ayo-Adesanya had indeed told Patient B that she would be receiving an additional IM injection, and then secondly, went on to consider whether such action was 'appropriate'. By way of scene setting and context it also took into account the events which took place earlier in the shift.

The panel had regard to the evidence of Colleague 1, which stated that:

> *"Patient B was calm and Buki came in and started saying she was going to give her an IM because of what she had done. Patient B shouted and asked her to leave, but Buki continued to say she needed an IM"*

The panel became aware during evidence taking that some witnesses have reported that the way Miss Ayo-Adesanya conducted herself/her presence would at times be a 'trigger' to certain patients, including Patient B.

The panel also had regard to the evidence of Witness 10, which stated:

"[Colleague 1] came to tell me she had heard Buki telling Patient B that she would be getting an IM again in a few minutes. I called Buki into the office and asked about what I had been told as it was not appropriate for her to say this to the patient. Buki told me she was just informing Patient B of the decision that had been made between the doctor and herself. Buki told me she had made another call to the doctor to explain Patient B's presentation, as this hadn't changed after the IM and was still very threatening and destructive. According to Buki the doctor had said another IM should be given if the behaviour continued, and our last resort if she was still not calm after this was seclusion. Buki said she wasn't saying it to get a reaction from Patient B but just to inform her. But from what she had heard, [Colleague 1] was of a view that Buki was taunting Patient B and trying to get a reaction."

The panel determined that the evidence of Witness 10 could be relied upon. This established that Miss Ayo-Adesanya did tell Patient B that she would have an additional IM injection. In the conversation that Witness 10 reports to have had with Miss Ayo-Adesanya, he recalled that Miss Ayo-Adesanya's explanation for her actions was that she was simply informing Patient B of the decision made by the doctor.

The panel then moved on to the issue of 'appropriateness'. The panel considered the evidence of Witness 5, where he outlined that the *"Indicators for IM administration of tranquilisers include patient refusal to comply with their treatment plan, non-response to verbal de-escalation, presentation of aggressive and/or challenging behaviour, and refusal to accept oral tranquilisers. These would trigger the 'rapid tranquilisation protocol'".* The panel also had regard to the NICE guidelines referred to earlier.

The panel was presented with consistent documentary and witness evidence that Patient B was being threatening and physically aggressive, where other methods of de-escalation and restraint had failed. It also had sight of Patient B's care plan and clinical notes recorded on 2 May 2017, where Patient B was reported to have been administered IM Lorazepam *"due to increasing risk of violence and physical*

aggression". It had first-hand accounts before it that Patient B was making verbal threats, attempted physical assault and continued to remain disruptive and unresponsive.

The panel therefore concluded that, in light of the context surrounding this charge, Miss Ayo-Adesanya informing Patient B about the additional IM injection was appropriate. It concluded that her actions were clinically appropriate, given that it is reasonable for a nursing professional to notify a patient before administering any medication, preparing them for the process.

The panel was mindful that intention was difficult to assess. Furthermore, it was presented with evidence from witnesses who were reporting a conversation they had viewed on CCTV footage without sound. The panel did not have sight of such footage.

The panel acknowledged however, that considering the events earlier in the shift, Miss Ayo-Adesanya in being the nurse and by conveying the doctor's decision to Patient B might have had a triggering effect on Patient B. However, the panel was not convinced that Miss Ayo-Adesanya intended to 'taunt' or elicit a reaction from Patient B. Therefore, it was not satisfied that her action of ‘telling’ was inappropriate.

The panel determined that the NMC had not discharged its burden of proof.

Accordingly, the panel finds charge 7 not proved.

Background / Preamble for charges 8 to 13

In consideration of the next set of charges, the panel had regard to documentary and oral evidence from a number of witnesses, notably, Witness 1, Witness 2, Witness 4 and Witness 19. These witnesses all viewed the CCTV footage (without sound) and reported seeing Patient B as relatively calm at points at which the IMs were attempted or being administered by Miss Ayo-Adesanya. These witness descriptions

are at times quite specific and graphic/emotive in nature. However, the panel was also aware that not all of the footage was available or captured, in particular to events and circumstances prior to the administration of the IMs. Therefore, the panel determined that these witnesses did not have the benefit of the full context of what was taking place during the shift when viewing the CCTV footage. Conversely, as stated in the submission from Miss Ayo-Adesanya and the witness account of Witness 5 and the direct witness account of Witness 10, the panel had evidence to suggest that Patient B was quite agitated, making verbal threats and physical threats particularly towards Miss Ayo-Adesanya.

Charge 8

> *"8. Attempted to administer the IM injection to Patient B in her bedroom which was not appropriate."*

This charge is found proved.

In reaching its decision, the panel first considered whether Miss Ayo-Adesanya had attempted to administer the IM injection in Patient B's bedroom and then secondly, whether this was appropriate.

The panel took into account the witness evidence of Colleague 1, which stated that when she was *"taken off observations to help with a PRN IM (intramuscular injection) for Patient B"*, she saw *"nurse Buki came in with the IM and said to put holds on her"*. Colleague 1 stated that she questioned it and *"mentioned that we don't normally do IMs in bedrooms"*.

The panel also had regard to the evidence of Witness 10, which supported the evidence provided by Colleague 1. He stated that Colleague 1 told him that Miss Ayo-Adesanya *"had first taken Patient B to her bedroom to give the IM".* The panel noted that both witness accounts were consistent in oral testimony.

The panel also considered Miss Ayo-Adesanya's written reflections, which confirmed this took place as she stated that she *"agreed to take [Patient B] to her bedroom and give her the IM there".* The panel was satisfied that there is credible evidence to establish that Miss Ayo-Adesanya attempted to administer the IM injection in Patient B's bedroom.

The panel then considered the 'appropriateness' of taking such actions. It had regard to the evidence of Witness 10 that:

> *"…an IM would not normally be administered in a bedroom as it must be done where there are cameras for staff protection in case of any allegation afterwards"*

It also heard oral evidence from Witness 10 that reported the Ward manager being involved with Miss Ayo-Adesanya's assistance in administering an IM in Patient B's bedroom a couple of nights ago. He reports this as becoming apparent to him through the investigation process, though he was not aware of this at the time. There was no supportive or corroborative evidence before the panel to rely upon to give weight to this information. The panel was therefore satisfied that there were other more definitive and consistent accounts from witnesses that IM injections being administered in the bedroom was not appropriate.

Further, the panel took account of Miss Ayo-Adesanya's written reflection where she stated that she *"felt the bedroom was a better place to maintain privacy and dignity".* The panel had regard to the Trust policy in this regard. It noted there was evidence to suggest that such measures may be appropriate in some instances, such as in emergency situations.

The panel accepted the evidence of Witness 10 that it was Trust policy to administer medication where there were cameras, not only for the protection of staff but also for patients. The panel also considered the context and Miss Ayo-Adesanya's earlier engagement with Patient B. It was satisfied that, on the balance of probabilities, it

was not appropriate for the IM injection to take place in the bedroom. The panel noted that, ultimately, the IM was administered in one of the de-escalation rooms, but nevertheless, the 'attempt' was not appropriate.

Accordingly, the panel finds charge 8 proved.

Charge 9

> *"9. Administered an IM injection of Lorazepam to Patient B at approximately 23.46 without clinical justification."*

This charge is found NOT proved

In reaching this decision, the panel took into account all the documentary and witness evidence before it.

The panel was satisfied that there were multiple witness accounts that testify to the time as set out in the charge, particularly that of Witness 19, as she reviewed CCTV evidence that showed Patient B *"was restrained in the de-escalation room at 23:42 hrs…and was ultimately administered medication at 23:46 hrs...This medication was administered by Bukola."*

To assess whether there was 'clinical justification', the panel had regard to the Trust policy, specifically 'Rapid Tranquilisation - Supplementary Guidance for Young People Aged 6 - 17 Years', which indicated that rapid tranquilisation is to be used *"as a last resort and…only when the risk is high and immediate and when other interventions have failed"*. The panel considered the evidence of Witness 5, who provided 'indicators' of when it is clinically justified to administer an IM injection.

The panel considered the evidence of Witness 19 upon reviewing the CCTV footage:

"77. At the point where Patient B was restrained (23:36 hrs), she was calm and there was no clinical need for her to be restrained. The CCTV footage showed no signs of any behaviour which would even come close to what I would consider could be described as "extreme agitation." On the contrary, Patient B remained calm throughout the restraint, and even when she was restrained in the de-escalation room at 23:42 hrs, Patient B did not appear to be struggling. It is my professional opinion that Patient B was ultimately administered medication at 23:46 hrs which she did not need. This medication was administered by Bukola."

The panel was satisfied that Witness 19's oral evidence was consistent with her written statement and the CCTV footage notes. However, it also noted that Witness 19 reviewed the footage without sound and was not directly present to witness the events that preceded. The panel did not have sight of the CCTV footage and was concerned about the degree of interpretation and inference that this witness was relying upon to form quite conclusive statements about the events taking place on camera.

The panel had regard to the evidence of Witness 10 as he was present when the IM injection was being administered, he stated:

"I was present, and I remember when this was taking place I was going to administer it, but Buki couldn't hold Patient B as her close proximity was escalating her behaviour. So I took over the hold and Buki gave the IM instead."

The panel considered that Witness 10's description of behaviour *"escalating"* suggested that there was a degree of risk which Patient B was posing. It also had regard to evidence of Patient B's behaviour prior to this such as, in Miss Ayo-Adesanya's account, that Patient B *"verbally assaulted", "physical attacked with sand", "punched in the face and kicked in the leg"* and *"threated to kill"* her. This

demonstrated that Patient B's behaviour by this point in the shift was *"disruptive"* and *"escalating"*, as per the evidence of Witness 10.

The panel determined that due to the inherent limitations of the CCTV evidence without sound, the panel found difficulty in attaching weight to the account of Witness 19. It also considered that there was evidence from multiple witnesses suggesting that Miss Ayo-Adesanya's presence was triggering for Patient B, therefore, it was more likely than not that Patient B exhibited *"escalating behaviour"* and likely posed a high risk, which meant that the IM injection at 23:46hrs was clinically justified.

Accordingly, the panel finds charge 9 not proved.

Charge 10

> *"10. Did not give Patient B the option of receiving Lorazepam orally."*

This charge is found NOT proved.

In reaching this decision, the panel took into account all the documentary and witness evidence before it, including the CCTV notes, Patient B's care plan, the Trust's NICE policy guidelines and Miss Ayo-Adesanya's written reflections.

The panel had regard to the evidence of Witness 19 on her review of the CCTV footage:

> *"I saw no interchange between Bukola and Patient B as I reviewed the CCTV footage which would support there having been a conversation between Bukola and the patient in respect of the route of medication administration…Patient B's medication care plan required consideration to be given to an oral route before IM was administered.*

Accordingly, I would have expected to see footage showing Bukola approaching Patient B whilst holding / carrying a pot of medication. I would also have expected to see Bukola having a discussion with Patient B regarding tablet form medication and this being offered to Patient B. I saw nothing like this. Nurses are always trained to offer oral medication in the first instance…As a Nurse working in a setting like PICU, Bukola should have tried to encourage Patient B to consider oral medication and should have discussed this with the patient."

Whilst the panel accepted Witness 19's professional opinion and acknowledged her description of good practice, it recognised that the CCTV footage was limited by the fact that it was viewed without sound, and therefore made it impossible to conclusively discern whether any such conversation took place or not.

The panel also had regard to the evidence of Witness 10 that he:

"offered Patient B an oral PRN (as needed) medicine and she refused. A call was made to the duty doctor about the incident and the duty doctor authorised an intramuscular PRN injection for rapid tranquilization (IM) to be given if necessary"

The panel recognised that whilst Miss Ayo-Adesanya may not have offered this option to Patient B herself, the panel was satisfied that the protocol was followed by the nurses who were working together. It considered the context whereby Patient B had earlier altercations with Miss Ayo-Adesanya, so it was more appropriate for Witness 10 to offer the oral medication as it was less likely to be refused by the patient. The panel determined that it was also more likely than not that Witness 10 and Miss Ayo-Adesanya communicated with one another that Patient B refused medication. The CCTV footage with no sound would not have captured such discussions.

Accordingly, the panel finds charge 10 not proved.

Charge 11

> *"11. After administering the IM injection to Patient B at 23.46 did not take/or ensure that the patients vital signs were monitored /or observed."*

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the documentary and witness evidence before it.

The panel had regard to the evidence of Colleague 1 and Witness 19. It also had no records of observations on Patient B. However, the panel carefully considered that the CCTV footage notes exhibited by Witness 19 stated that at 00.15 hours, Patient B's *"post IM obs"* were completed by Witness 10.

The panel considered that the evidence of Witness 10 demonstrates awareness and adherence to:

> *"the protocol to carry out patient observations after giving a rapid tranquilization and we do this soon after the IM, then every ten minutes. We tried after five minutes and Patient B refused, but she allowed us to commence these after ten minutes and they were repeated after 20 minutes, by which time she had calmed down."*

The panel accepted that whilst there are no records of observations at exactly 23:46, which may have been due to the circumstances at the time and the patient's refusal, there was evidence that Patient B's vital signs were being observed. It noted it was likely that there was communication between Witness 10 and Miss Ayo-Adesanya, which may not have been captured by the CCTV footage without sound. The panel accepted the evidence of Witness 10 and found it to be credible and reliable.

Accordingly, the panel finds charge 11 not proved.

Charge 12

> *"12. Administered an IM injection to Patient B at approximately 2.20hrs without clinical justification."*

This charge is found NOT proved.

In reaching this decision, the panel took into account all the documentary and witness evidence before it, including the evidence of Witness 19 who reviewed the CCTV footage (without sound).

The panel also accepted evidence from Witness 10 which describes the situation in the Unit and Patient B's behaviour. It accepted Miss Ayo-Adesanya's written response which describes Patient B's behaviour as being disruptive/unresponsive to verbal de-escalation. Whilst accepting this, the panel did acknowledge the evidence of Colleague 1 which contradicted this. In her evidence, she stated that they *"had it under control"* but also suggested that Miss Ayo-Adesanya's manner would *"provoke"* the patient.

The panel noted that Miss Ayo-Adesanya, in her written responses during the investigatory meeting notes, stated that she contacted Witness 5 on various occasions as Patient B was *"getting out of hand".*

The panel determined that Witness 5 (the on-call doctor) had authorised the second IM injection at 2.20hrs when he stated in his written evidence:

> *"Patient B is recorded as not having responded positively to the 23.55 hours IM administration of Lorazepam and continued to disturb the ward and threaten staff. The Registrant documented that I then advised that if Patient B's behaviour remained disruptive and unresponsive to verbal de-escalation,*

25mg of IM Promethazine was to be administered, and staff were to consider secluding Patient B as a last resort."

The panel determined that given that Miss Ayo-Adesanya had consulted the doctor on duty and *"sought the right support and advise"*, on the balance of probabilities, it was more likely that the IM injection administered to Patient B at approximately 2.20hrs was clinically justified.

Accordingly, the panel finds charge 12 not proved.

Charge 13

"13. Did not give Patient B the option of receiving medication orally."

This charge is found NOT proved.

The panel began by noting that the NMC primarily relies on the evidence Witness 19, who had reviewed the CCTV footage (which had no sound and was indicated to be incomplete). The panel recognised that Witness 19's evidence correctly outlines what should have happened ideally but acknowledged that she was not directly present during the events and that her conclusions relied heavily on CCTV evidence which in itself was limited.

The panel heard oral evidence from Witness 19 during which it was conceded that she could not be certain of whether or not discussions about oral medication had taken place between Patient B, Miss Ayo-Adesanya and/or Witness 10.

The panel was not satisfied that the NMC discharged its burden of proof.

Accordingly, the panel finds charge 13 not proved.

Charge 14

“14. Threatened an unknown patient with an IM injection if they did not go to their room.”

This charge is found proved.

In reaching this decision, the panel referred back to its earlier considerations on the word ‘threaten’.

The panel had regard to the evidence of Colleague 1 that she:

“…heard Buki saying to a patient "You need to go to your room now." The patient answered "I need to wait here for [Witness 10]", and Buki said "Go to your room now if you don't want an IM"

The panel considered the evidence of Colleague 1 to be consistent in oral evidence and credible. The panel accepted that a reasonable person would interpret such an expression as a threat, as the IM injection in this context appears to be presented in a hostile manner and as a retribution for the patient if they do not go to their room.

Accordingly, the panel finds charge 14 proved.

Charge 15

“15. On one or more occasions pointed your finger at one or more patients which was inappropriate in that it is an aggressive way of communicating.”

This charge is found proved.

In reaching this decision, the panel decided that it could place weight on the evidence provided through CCTV footage. Though this footage lacked sound, this specific charge focused on the ability to identify the 'pointing a finger', something which could clearly be seen and evidenced by viewing CCTV footage.

The panel had regard to the evidence of Witness 19 which identified that:

> *"Bukola frequently pointed her finger at the young people which simply served to "trigger" them. Bukola's presence and manner came across as aggressive and confrontational and additionally, she did little to avoid confrontation, which I felt that she could have done in the circumstances"*

The panel was satisfied that Witness 19 was consistent in her oral evidence and that although the CCTV had no audio, the action of pointing a finger would have been identifiable as outlined and supported by the CCTV notes which she included as part of her evidence.

The panel was satisfied that multiple witnesses had corroborated the evidence of Witness 19 i.e. that Miss Ayo-Adesanya had indeed pointed her finger at patients. This was also supported by Witness 4. In her oral evidence, Witness 4 confirmed that she saw Miss Ayo-Adesanya *"finger pointing"* and that it was *"not collaborative"* and *"does not help".* The panel was satisfied, on the balance of probabilities, that this was an inappropriate way of communicating with patients or any individual.

Accordingly, the panel finds charge 15 proved.

Charge 16

> *"16. Were not visibly present to patients."*

This charge is found NOT proved.

In reaching this decision, the panel took a narrow and literal interpretation of the word ‘visible’ as set out in this charge. It also took into account that there is CCTV evidence, reviewed by Witness 19, that the panel can rely on to establish as to whether Miss Ayo-Adesanya was present and visible, including fulfilling her duties to look after patients. The panel determined that there is evidence to confirm that Miss Ayo-Adesanya was visible and present to patients. There is also evidence from Colleague 1 and Witness 10 which refers to the effect of Miss Ayo-Adesanya’s *“presence”* on patients, namely that her very presence in and around the unit was ‘triggering’. Indeed, the panel heard evidence where at least one colleague had advised Miss Ayo-Adesanya to be *“invisible and stay in the office”*. She appears to have initially heeded this advice at the earlier part of the shift.

The panel also acknowledged the professional judgement of other senior colleagues, who have offered views on the wider matter of nurse leadership and professional conduct. This suggested that Miss Ayo-Adesanya should in their opinion have demonstrated more active engagement with patients and colleagues. However, given the specific wording of this charge, the panel was satisfied that there was sufficient evidence before it to show that Miss Ayo-Adesanya was visibly present during her shift.

Accordingly, the panel finds charge 16 not proved.

Charge 17

> *“17. On witnessing Patient B being restrained inappropriately, did not intervene as manager.”*

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence from Witness 19 upon reviewing the CCTV footage:

"64. Although Bukola wasn't the instigator of the restraint at 23:36 hrs, and wasn't involved in the actual process of restraining, as the Nurse in Charge, she had a professional duty to consider whether that restraint was justified and challenge any poor practice or inappropriate techniques which she witnessed…In a hospital setting, restraints often happen very quickly however, this was not the case with Patient B. The patient was sitting quietly in a communal area on the Ward at 23:36 hrs. I assume she may have been refusing to go to bed, however there was no sign of aggression or agitated behaviour on the CCTV. And a refusal to go to bed would not warrant an immediate restraint."

The panel carefully considered Witness 19's interpretation of events having reviewed the CCTV footage. However, the panel recognised that this evidence is limited in that the CCTV evidence is incomplete as there is no audio and no context to consider about the circumstances leading up to the restraint of Patient B. It noted that Witness 19's evidence is based on what she could *"assume"* from the footage she had available to her. The panel was not sufficiently persuaded that this evidence can be relied upon and concluded that the NMC had failed to discharge its burden of proof.

Accordingly, the panel finds charge 17 not proved.

Charge 18 and 19

"18. In relation to Patient A did not ensure that appropriate de-escalation techniques were utilised before the patient was physically restrained.

"19. Did not provide oversight or management regarding the restraint of Patient A."

These charges are found NOT proved.

In reaching this decision, the panel considered charges 18 and 19 individually at first and then collectively as it determined that they are inextricably linked.

In respect of charge 18, Witness 19 stated that:

> "*As I watched the CCTV, I didn't view any footage where there seemed to be any sort of interchange which would suggest that staff were trying to encourage to put the knife down. I feel like instead of de-escalation, staff employed another restraint and again used it as a first point option, rather than a final option, when all other methods of de-escalation had proved unsuccessful."*

In respect of charge 19, Witness 19 stated that *"as the Nurse in Charge of PICU that evening, Bukola had a responsibility to maintain oversight of the restraint process to ensure that it was clinically justified and was carried out in a way which protected the safety and dignity of Patient A".*

The panel also heard evidence from Witness 10 that Patient A had taken a knife into the bathroom with her, alarms were raised, and staff responded. He outlined that *"all efforts by staff to remove the knife failed in the bathroom. She moved into the corridor and then the general area where staff managed to take the knife from her in restraint".* The panel considered that the evidence of Witness 10 provided relevant context to what took place and determined that it was possible that attempts at de-escalation may have been undertaken inside the bathroom, away from the view of the cameras, as Patient A had initially taken the knife there with her.

Having heard evidence that some of the events took place in the bathroom, a private place with no cameras, making it impossible to evidence what exactly took place. Thus, the panel concluded that the CCTV footage (without sound) relied upon by Witness 19 was likely incomplete. Due to the limitations of the available footage, the panel concluded that Witness 19 could not establish the precise nature of events.

Therefore, the panel was not satisfied that the NMC had discharged its burden of proof.

Accordingly, the panel finds charges 18 and 19 not proved.

Whilst working for Cygnet Hospital, Godden Green

Charge 20

"20. On one or more of the following occasions claimed that you had worked your full shift when you had not:

a. 20 September 2017.
b. 4 October 2017.
c. 5 October 2017."

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all the documentary and witness evidence before it. The panel considered the charges individually at first, and then collectively.

The panel had sight of the CCTV footage for the dates of 4 and 5 October 2017 and determined that this was compelling evidence which established that Miss Ayo-Adesanya arrived late on these specific dates as there is a date and time stamp shown against the footage. The panel also had regard to witness evidence which corroborates this, notably from Witness 6, 7 and 9. It was satisfied that their oral evidence was consistent with their written statements. The panel was satisfied that the CCTV evidence supported what Witness 6 had reported to Witness 7, i.e. that Miss Ayo-Adesanya was *"continuously late to work"*, something which is expanded upon in his email complaint dated 6 October 2017.

Whilst the panel did not have sight of CCTV footage on 20 September 2017, the panel considered that there was consistent and credible witness evidence to support this charge. It also noted that the stem of the charge stated: *"on one or more of the following occasions"* and accepted that having evidence for one occasion could suffice to find this charged proved.

Accordingly, the panel finds charges 20 (a), (b) and (c) proved.

Charge 21

> *"21. Your actions at charge 20 a, and or b and or c were dishonest in that you sought to create the impression that you had worked your full shift when you knew that you had not."*

This charge is found proved.

To decide dishonesty, as defined in the case of *Ivey v Genting Casinos,* the panel must be satisfied of the following:

1. What did the Registrant do and/or say?
2. What was her actual state of mind and her knowledge and belief as to the facts?
3. Once the panel decided what she did and what her actual state of mind was, it will consider whether her conduct with that state of mind would be considered dishonest by ordinary and decent people.

Having found the facts at charges 20 (a), (b) and (c) proved, the panel looked closely at Miss Ayo-Adesanya's actions from the perspective of what she would have known in the circumstances. It concluded that her actions were deliberate and dishonest. It accepted that she was responsible for completing her timesheets correctly. The panel was satisfied that Miss Ayo-Adesanya must have known she was late to work

on occasions, and in deliberately claiming for those hours, she sought to create the impression that she worked full shifts when she knew she had not.

The panel determined that this would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel finds charge 21 proved.

Charge 22

> *"22. On one or more of the following occasions claimed that you had attended your shift when you had not:*
>
> *a. 22 September 2017.*
> *b. 30 September 2017.*
>
> *Your actions at charge 22 (a) and/or (b) were dishonest in that you sought to create the impression that you had attended work when you knew that you had not."*

This charge is found proved in its entirety.

In reaching this decision, the panel considered the charges individually at first, and then collectively. The panel noted that the stem of the charge stated: *"on one or more of the following occasions"* and accepted that having evidence for one occasion could suffice to find this charged proved.

The panel had sight of various documentary evidence, including signing in sheets, timesheets and investigation reports carried out by Witness 7. On the report dated 24 October 2017, under the section for attendance, Witness 7 stated:

"*On 22 and 30 September 2017 Mrs Ayo-Adesanya was on the rota to work but was not on shift, Mrs Ayo-Adesanya was asked to explain the circumstances why she hadn't turned up for work, Mrs Ayo-Adesanya replied "I don't know what happened then, [PRIVATE] issues. I requested annual leave, I spoke to [Team Leader 1]. I called the Ward and spoke to him". No evidence of any paperwork regarding annual leave request for those 2 days could be found, [Team Leader 1] confirmed that no annual leave requests were received by him…Timesheet for this period showed Mrs Ayo-Adesanya had entered 11 hours night shift for both dates."*

The panel noted that Witness 7's evidence says that Miss Ayo-Adesanya gave *"[PRIVATE]"* as an explanation for absence. It was satisfied that from her perspective this represents a tacit admission that she did not attend her shift on those dates. It had sight of the handwritten statement from Team Leader 1 dated 10 October 2017, which confirmed that Miss Ayo-Adesanya did not request annual leave for those dates. The panel also had sight of the timesheets and was satisfied that Miss Ayo-Adesanya had claimed to have worked on these shifts.

The panel considered the matter of dishonesty separately. It noted that Miss Ayo-Adesanya has extensive experience as an agency nurse and therefore should be familiar with the process of completing timesheets and their importance. The panel attached weight and plausibility to the account given by Witness 7 and was satisfied that, on the balance of probabilities, it was more likely than not that Miss Ayo-Adesanya must have known that she had not worked the shifts she had claimed for and therefore was deliberate and dishonest in her actions.

The panel determined that this would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel finds charges 22 (a) and (b) proved.

Charge 23

> *"23. On 29 September 2017 claimed to have attended Breakaway Training when you did not."*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7. It noted that there was contemporaneous evidence from Witness 7 in his investigation report dated 20 October 2017, where he stated that *"Mrs Ayo-Adesanya was due to undertake Breakaway training which is Mandatory training…Mrs Ayo-Adesanya failed to attend this training and entered 7.5 hours on her time sheet".*

The panel also had sight of Miss Ayo-Adesanya's responses at the investigation meeting with Witness 7 on 17 October 2017, where she stated that she was "*[PRIVATE]".* The panel was satisfied that this appeared to be a partial admission as her response indicated that she likely forgot about the training due to [PRIVATE], and therefore, it would follow that she did not attend.

The panel had sight of the timesheet completed by Miss Ayo-Adesanya for the date 29 September 2017, where she claimed 7.5 hours. It noted that the timesheet was signed by Miss Ayo-Adesanya and was satisfied that she had claimed the hours for training when she knew she had not attended this mandatory training.

Accordingly, the panel finds charge 23 proved.

Charge 24

> *"24. Your actions at charge 23 were dishonest in that you sought to create the impression that you had attended the training when you that you had not."*

This charge is found proved.

In reaching this decision, the panel referred back to its findings at charge 23, which is inextricably linked to this charge. It acknowledged that having found charge 23 proved this did not automatically constitute a finding for this charge.

The panel had regard to the documentary evidence before it, particularly the timesheet and her responses at the investigatory interview with Witness 7. It was satisfied that Miss Ayo-Adesanya must have known that she did not attend this training and, in deliberately completing her timesheet claiming for those hours, she more likely than not sought to create the impression that she attended the training, when she had not. The panel therefore concluded that her actions were dishonest.

The panel determined that this would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel finds charge 24 proved.

Charge 25

> *"25. On 5 October 2017 continued to use your mobile phone despite being aware that you were not supposed to use it."*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7, where he outlined that:

> *"On 5 October 2017 the Ward receptionist…provided…a statement she had written concerning Buki contravening the mobile phone usage policy after this had been highlighted to her. [Ward Receptionist] had been asked to ensure that all staff read the mobile phone policy document and signed a record*

confirming this. Buki was in the office looking at her phone and eating popcorn, when [Ward Receptionist] walked in and gave her the policy to read. Buki signed the policy and handed it back, before continuing to watch her phone."

The panel bore in mind that Witness 7 was not a direct witness to the events, however, this was reported to him by multiple staff and the panel had seen documentary evidence from the Ward receptionist to support it. It read the statement made by the receptionist, which was signed and dated 5 October 2017.

The panel was also presented with direct witness evidence from further witnesses. Witness 6, stated that he remembered:

"one occasion Buki had been sitting in the office and had been using FaceTime to talk to her family. She turned the phone around and showed her family to [him], saying she was there with a colleague"

It also had evidence from Witness 9, who set out on his statement dated 10 October 2017, that *"on two consecutive nights [he had] observed Buki administering medication while talking on her personal mobile".* It noted that Miss Ayo-Adesanya denies this assertion of using her phone while administering medication. However, the panel was mindful that there appeared to be more than one witness who had seen her, on at least one occasion, using her mobile phone.

The panel was satisfied that a policy was in place and had been communicated to Miss Ayo-Adesanya prohibiting the use of mobile phones at work. It noted that this was signed by Miss Ayo-Adesanya. The panel determined that in signing the policy, Miss Ayo-Adesanya accepted that she had read the policy and therefore, on the balance of probabilities, was aware that mobile use at work was not allowed.

The panel had regard to Witness 7's evidence in the investigatory report that:

"when asked about bringing her mobile phone onto the ward at night, Mrs Ayo-Adesanya didn't deny it but said 'if you go through CCTV you would see that everyone else does'"

The panel accepted that Miss Ayo-Adesanya did not deny bringing her mobile phone onto the ward. It noted that 'bringing' does not constitute 'using'. However, on the basis of the cogent witness evidence before it, the panel was satisfied that it was more likely that not that Miss Ayo-Adesanya used her mobile phone despite being aware that she was not supposed to use it.

Accordingly, the panel found charge 25 proved.

Charge 26

"26. On 6 October 2017 did not carry out patient observations which you were assigned to do between 11pm to midnight."

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 7 and Witness 9.

The panel had regard to the evidence of Witness 7 where he set out that:

"on 6 October 2017 Buki been assigned to do patient observations for an hour between 11pm and midnight, during which time CCTV footage showed she never left the nursing station".

The panel was of the view that the evidence of Witness 9 supported the evidence of Witness 7 as he stated on 10 October 2017. In which he reports that he handed the clipboard and observations sheets at 22:00 but upon returning at midnight to collect

them "*the clipboard hadn't moved"* and *"the observation sheets were completely blank, which suggested that Buki had not carried out observations at all".*

The panel noted some minor discrepancy with dates in the evidence before it but noted the supplementary witness evidence of Witness 9, which clarified that the 10 October 2017 date in his initial statement may have been wrong, and he could not remember the date due to the passage of time. The panel carefully considered this and noted that Witness 7 referred to CCTV footage which he had reviewed. It was satisfied that the evidence of Witness 7 and Witness 9 was likely to be referring to the same shift.

The panel also took account of Miss Ayo-Adesanya's response:

> *"Conducting observation checks should never at any point be taken lightly as it is a way of ensuring and maintaining patients' safety. I will never in any way have acted in an unprofessional way to jeopardise patient's safety. I can confirm that I have always carried out observations assigned to me on any shifts I've worked on Saltwood Ward. I believe if these allegations were true that Cygnet should have taken this up with me immediately as soon as reported but that was not the case. There was never a time I have been asked to attend a supervision to address this issue before the allegations were reported to the NMC."*

The panel considered that whilst there is no evidence that this concern was formally raised in supervision meetings with Miss Ayo-Adesanya, it determined that there is consistent witness evidence that concerns were raised with her informally and on more than one occasion.

Accordingly, the panel finds charge 26 proved.

Charges 27

"27. On one or more of the following occasions left one or more patients to dispense their medication without supervision:

a. 2 September 2017.
b. 21 September 2017."

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all the documentary and witness evidence before it. The panel considered the charges individually at first, and then collectively.

The panel had regard to the evidence of Witness 7 that upon reviewing the CCTV footage he was concerned about her practice as although some of the patients are self-medicating, *"they still need to be observed dispensing and swallowing this. Instead, Buki could be seen turning her back on patients after handing them their medication."* The panel found his oral evidence to be consistent as Witness 7 confirmed that *"she should have been any medication near the Hatch. She should have been observing it".*

The panel noted that Miss Ayo-Adesanya denies this assertion in her written responses, stating:

> *"Neither have I left any patient unattended during medication administration. I fully understand the procedures and I have not been summoned for any questioning as a result of this at any point in time during my time on Saltwood Ward."*

The panel had sight of the CCTV footage for the dates of 2 and 21 September 2017 and determined that this was compelling evidence that showed Miss Ayo-Adesanya walking away from the hatch after handing the medication tray to the patients, and therefore, left patients to dispense their medication without supervision.

Accordingly, the panel finds charges 27 (a) and (b) proved.

Charge 28

"28. On one or more occasion slept whilst on duty."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and Witness 9. The panel also had regard to the written response from Miss Ayo-Adesanya, which disputed this saying that: *"I have not ever slept whilst on duty as alleged".*

The panel was presented with direct evidence from Witness 6 of an occasion where Miss Ayo-Adesanya *"arrived back from her break 2 hours late…and walked straight into the lounge and went to sleep".* It considered that other witnesses, notably Witness 9, had also directly observed similar behaviour as he stated: *"on return from breaks Buki will on occasions sit in the lounge and sleep".*

The panel found that the witness evidence was corroborative and consistent with their oral evidence. It was satisfied that the evidence was credible and could be relied upon. Accordingly, the panel finds charge 28 proved.

<u>Whilst working for Winchester House Care Home</u>

The next set of charges relate to Marconi Unit, which is situated on the ground floor of Winchester House Care Home. The panel heard evidence describing Marconi as a low intensity unit that housed up to 11 residents, requiring residential care with diverse needs, including early onset Dementia and Parkinson's Disease. Being a low intensity unit, the majority of resident are mobile, can manage self-toileting, and require minimal care. This description of the care needs of residents helped the

panel understand the sorts of requirements that might be placed on staff when it came to assistance with personal care.

At the time of the incident in November 2020, there were around 10 residents, with only one needing bathroom assistance. The panel heard evidence that confirmed that assistance with bathing primarily involved gentle reminders and staff providing washcloths, rather than more personal care.

Charge 29

> *"29. On 4 November 2020 on being advised by Colleague 2 that a resident may need some help with washing and dressing stated 'I don't do personal care' or words to that effect"*

This charge is found proved.

The panel heard evidence from several colleagues who had provided cogent and/or corroborative evidence, starting with Colleague 2, who stated:

> *"Around 20:45 hrs (on 4 November 2020), I started my handover with Bukola at the first room…I went on to say that in the morning, the resident liked to get up at 07:00 hrs and that Bukola would just need to help the resident wash and get dressed. At this point, Bukola immediately handed back the medication keys and said, "I don't do personal care." I replied, "You have to give personal care you're the only one here, you need to help the residents." Bukola then said something very close to, "I'm a nurse, and I'm not risking my PIN" and then walked out the door and left the unit…I have never encountered a situation where a Nurse has refused to help with personal care".*

The panel also heard oral evidence from Colleague 2 and found it to be consistent with her written statement as well as her emailed 'letter of complaint' to Witness 14, dated 5 November 2020.

The panel found that this evidence was supported by Witness 14, who stated that:

> *"although providing personal care isn't strictly the day-to-day role of the Registered Nurse on duty, as a Registered Nurse you're expected to work as part of the team…If any of the staff, either one of the Carers or another Registered Nurse, needs assistance, there's an expectation that all other staff will pitch in to help…Bukola's role as a Nurse working at Winchester House was to make sure that care was delivered, and that residents' needs were met. There shouldn't be any hierarchy in respect of who delivers the care".*

The panel heard further supporting oral evidence from Witness 14 and Witness 13. Witness 13 in her oral evidence, in response to a question from the panel, stated that:

> *"every single nurse helps carers, personal care is not in the job description but it is expected"*

The panel also had regard to contemporaneous documentary evidence. In her email to Witness 14 on 5 November 2020, Colleague 2 said that:

> *"Bukola responded that she doesn't do personal care…I said that she had to help the residents as she was the only person in the unit, to which she replied that she would have to talk to [Witness 11] and passed me the keys back and…said she wasn't going to risk her pin and that personal care was a carers job and she was not a carer she was a nurse"*

The panel then considered Witness 11's contemporaneous handwritten statement dated 4 November 2020, which stated that Miss Ayo-Adesanya told him that:

> *"she was going home as she is not happy with the handover because it's too quick and cannot understand anything as it's her first shift in the unit. Also she said, she is not confident doing the caring job as she is afraid to lose her PIN number if she makes a mistake".*

The panel found his NMC witness statement and oral evidence to be consistent with his contemporaneous account which other colleagues' evidence that Miss Ayo-Adesanya was not keen on doing personal care for residents.

The panel therefore concluded that it was proved, on the balance of probabilities, based on credible and reliable evidence from multiple witnesses, that on 4 November 2020 on being advised by Colleague 2 that a resident may need some help with washing and dressing, Miss Ayo-Adesanya did say *'I don't do personal care'* or words to that effect.

Accordingly, the panel finds charge 29 proved.

Charge 30

> *"30. Made the comment as detailed in charge 29 within earshot of other residents at the home."*

This charge is found proved.

The panel considered this charge separately, however, it was mindful that it was inextricably linked to charge 29 above because of where and when the incident took place.

The panel had particular regard to the evidence from Colleague 2 in relation to this charge:

> *"…a couple of the other residents who had been sitting in the lounge area at the time had overheard Bukola's comments. One of the residents had Parkinson's Disease but she had full capacity and I distinctly remember her saying that it was "a bloody cheek." I also remember one of our residents approaching me whilst I was speaking with Bukola."*

The panel took account of Colleague 2's contemporaneous evidence comprising a complaint sent by email about this incident, as well as her oral evidence. It noted that Colleague 2's evidence was consistent that her and Miss Ayo-Adesanya *"walked to room number one"* during handover, so the comments were made *"outside the resident's room, in the corridor"* and that following this, she had to *"reassure"* the resident.

The panel was therefore satisfied on the balance of probabilities that Miss Ayo-Adesanya made the comments set out in charge 29. It determined that there was credible evidence to also support that, on the balance of probabilities, Miss Ayo-Adesanya made these comments within earshot of other residents at the home.

Accordingly, the panel finds charge 30 proved.

Charge 31

> *"31. On 4 November 2020 left your shift early without authorisation."*

This charge is found proved.

There were multiple witnesses to the events surrounding this incident. Firstly, the panel had particular regard to the written and oral evidence of Colleague 2, who stated that Miss Ayo-Adesanya *"handed back the medication keys…and then walked out the door and left the unit"*. This was supported by Witness 11's oral and written evidence, which stated:

> *"I received a telephone call from Bukola. Bukola told me that she wasn't happy with the handover…that she was leaving…I told her that it wasn't appropriate for her to just walk out when we'd tried to accommodate her requests. I then started to make my way back to Marconi Unit with the intention of speaking to Bukola and finding out what was wrong. But before I*

could do this, I was approached by [Witness 13] who told me that Bukola had left. This meant I didn't have any opportunity to try and improve the handover or address Bukola's concerns. I was willing to look at solutions and would have considered moving some of the other staff around, but I didn't get the chance."

The panel also considered the evidence of Witness 13 who, in her oral evidence, stated that she heard Miss Ayo-Adesanya saying *"no I'm not staying, I'm not losing my pin for a carer"* or words to that effect.

The panel also took into account the written submissions of Miss Ayo-Adesanya:

"…For some background, [PRIVATE]. I informed management when I started working at WH as I was aware that there were some units [PRIVATE]. I become [PRIVATE] I made it clear to WH that I could not work on that unit.

[PRIVATE]
…
I placed several calls to the General Manager as advised, but I was unable to get hold of [Witness 14]. My calls were unanswered. I also called the Deputy Manager…a couple of times and still no joy. [PRIVATE].

I felt that by this point, I had no choice but to leave and [Witness 11] agreed with me. Looking back on the situation, I can see that this was not the only option for me and there were certainly things I would have done differently. I do not wish to excuse my actions, [PRIVATE] contributed to my decision and I have reflected on ways that this could have been alleviated. I do not want this to happen again and I am sorry for leaving WH when I did."

The panel accepted that there was consistent evidence from the witness accounts given by Colleague 2, Witness 11 and Witness 13, and Miss Ayo-Adesanya herself, which established that on 4 November 2020, she left her shift early and abruptly

without authorisation. It accepted evidence that workable arrangements had been made in the unit to accommodate Miss Ayo-Adesanya's phobia of cats.

The panel then turned its attention to the question of whether Miss Ayo-Adesanya had received authorisation for her absence. It noted that there was a discrepancy between the evidence of Witness 11 and Miss Ayo-Adesanya, in that she claims that Witness 11 *"agreed"* with her. The panel heard oral evidence from Witness 11 that her absence *"absolutely was not (authorised) and she just went out".* The panel found this to be consistent with his statement and handwritten local statement on the day of the incident. Therefore, the panel concluded that it was more likely than not that Miss Ayo-Adesanya left her shift early without authorisation.

Accordingly, the panel finds charge 31 proved.

Charge 32

> *"32. On one or more occasion used your mobile phone whilst on duty."*

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Colleague 2 and Witness 13 in relation to other concerns raised about Miss Ayo-Adesanya's practice, specifically including the use of a mobile device whilst on duty.

The panel first considered the evidence of Colleague 2, which stated that:

> *"Almost every time I saw Bukola at work, she was sitting in the nurse's station on her mobile phone. She did this a lot…on many occasions…overheard Bukola in the nurse's station talking on her mobile phone in her native language."*

The panel found that the evidence of a second witness (Witness 13) also supported Colleague 2's statement. In this she concurred by stating that:

> *"whilst Bukky was working, she would use her personal mobile phone a lot"* and *"often chatted on video calls whilst she was meant to be working"*

The panel was satisfied that this evidence was consistent with her oral evidence.

The panel noted that the wording of the charge is 'on one or more occasions', indicating that if the panel found it plausible that Miss Ayo-Adesanya used her mobile phone whilst on duty at least once, this would suffice to satisfy the burden of proof required for this charge. It therefore concluded that, on the balance of probabilities, Miss Ayo-Adesanya had used her mobile phone whilst on duty, at least once.

Accordingly, the panel finds charge 32 proved.

Charge 33

> *"33. Slept when you were supposed to be participating in mandatory training."*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 13 which were considered against Miss Ayo-Adesanya's written responses to the allegations.

The panel first considered Witness 13's evidence, which stated:

> *"I recall another time, around the start of the Covid-19 pandemic, when the Home Manager asked me to go around every Unit and show each staff*

member a video demonstrating of how to put on PPE and how to remove it correctly. I then took a laptop around each of the Units and spoke to each of the staff members and asked them to watch the video. When I arrived at the Unit Bukky was working on, I found her sleeping. I said "hi" and Bukky didn't even stir. Bukky would usually sleep with her hoodie on and her feet up on the table within the nursing office. When she didn't respond to me, I thought Bukky might have been sick so I put my hand on her shoulder to get her attention. She stirred and I said to her that she needed to watch the videos as a training aid. Bukky then said to me, "Get out of here with your training ". I replied, "Bukky this is mandatory so you have to watch it" and she did, but didn't really seem to pay much attention. Once the videos were finished, I went out to speak to other staff and when I went back on to Bukky's Unit a short time later, she was sleeping again."

Whilst the panel recognised that Witness 13 found Miss Ayo-Adesanya sleeping, it appeared that in her evidence she also recalled Miss Ayo-Adesanya to have participated in the training, however reluctantly, when she stated:

"Bukky then said to me, "Get out of here with your training ". I replied, "Bukky this is mandatory so you have to watch it" and she did, but didn't really seem to pay much attention".

The panel also noted that in her oral evidence, Witness 13 conceded that *"when she finally set eyes on it she was playing with her phone, but she did watch it".*

In arriving at its conclusion, the panel noted the charge specifically alleges Miss Ayo-Adesanya sleeping when she was supposed to participate in training as opposed to sleeping in general while on duty. It concluded that there was evidence from Witness 13 indicating Miss Ayo-Adesanya's participation albeit in a rather begrudging manner. It noted that her participation in the training was reluctant, but nevertheless, she did watch it and therefore technically participated. The panel was not satisfied that the NMC had discharged its burden of proof.

Accordingly, the panel finds charge 33 not proved.

Charge 34

"34. On one or more occasions slept whilst you were on duty."

This charge is found proved.

In reaching this decision, the panel accepted that there is a more general allegation of sleeping whilst on duty. It took into account its considerations in the previous charge and the evidence of Witness 13, Colleagues 3 and 4.

The panel first considered the evidence of Witness 13, who had *"received a number of complaints that Bukky was sleeping whilst on duty"* and had directly witnessed her sleeping on at least one occasion. She affirmed in her oral evidence that *"it was normal for her to be asleep on duty".*

The panel then heard evidence from Colleague 3, which it found to be supportive. Here the witness states that she also directly *"saw Bukky sleeping on duty on several occasions"* and *"knew she was asleep because her eyes would be closed, and she would be snoring".*

Finally, the panel also had regard to the evidence of Colleague 4 who recalled that *"Bukola was always asleep during the shift".* The panel noted that Miss Ayo-Adesanya denies this in her response to the charges. However, it concluded that there was consistent and corroborative evidence from multiple witnesses which substantiated that it was more likely than not there were one or more occasions Miss Ayo-Adesanya slept whilst she was on duty.

Accordingly, the panel finds charge 34 proved.

Charge 35 (35.1)

"35. On or around 18 April 2020, on becoming aware that Patient F was on the floor:

35.1 did not assist Colleague 3 in getting them off the floor."

This charge is found proved.

In reaching this decision, the panel first took into account the written and oral evidence of Colleague 3, which stated:

"I recall this incident clearly…I believe this incident would have taken place in or around March or April 2020…[Patient F] was elderly, suffered from dementia and had poor mobility; he used a wheelchair to get around. Due to his dementia, it was not uncommon for [Patient F] to climb out of bed thinking he could use his legs, but he could not, resulting in him falling.

On the night in question, I went to check on [Patient F]...When I walked in, I found [Patient F] lying on the floor between the chair next to his bed and the wardrobe in his room…I immediately placed a pillow underneath [Patient F]'s head to make him more comfortable then went to call Bukky, who was in the nurses' office, to help me get [Patient F] off the floor. Bukky came with me but when we got to the room said she did not know how to use a hoist, which is a piece of equipment we use to move residents, and that she was not going to learn how to at that time of the morning…I responded that we could not leave [Patient F] on the floor. Bukky told me that I should make [Patient F] comfortable on the floor by getting a sheet underneath him, covering him with a blanket and handing him over to the day staff that were due to start work at 08.00 hours. She then walked away, saying that she had loads of things to do before the end of her shift.

I was shocked by Bukky's response. As a trained nurse I would have thought that Bukky would know how to use a hoist, which requires two people to

operate…I also could not believe that she thought leaving [Patient F] on the floor for over an hour was acceptable."

The panel also heard oral evidence from Colleague 3 and found it to be consistent with her written statement.

To determine whether Miss Ayo-Adesanya had failed in her professional duty as nurse, the panel had regard to the 'Falls Policy 2017', which was in place at Winchester House at the time of this incident. It also looked at Patient F's care plans which confirmed that this patient was at *"high risk of falls"*. The care plan also sets out quite explicitly that *"staff should support Patient F with moving and transfers".*

The panel finally considered the evidence of Witness 14, which stated:

"As a staff nurse Bukola would and should have known how to use a hoist, which is a piece of specialist equipment used to transfer patients. All the staff in the Home receive face-to-face moving and handling training as part of the induction process, prior to commencing work. This includes how to use a hoist. Bukola received her Moving and Handling ('M&H') training on 18 July 2019. This was her initial M&H induction training before commencing work."

The panel was satisfied that the oral evidence of Colleague 3 and Witness 14 was consistent with the documentary evidence before it and it can be relied upon. It noted that Colleague 3 clearly recalled this event as she was *"shocked"* at Miss Ayo-Adesanya's response at the time.

The panel accepted the evidence it received about Patient F. It heard cogent and compelling evidence that the patient remained on the floor after Colleague 3 had informed Miss Ayo-Adesanya. This is corroborated by the account of the incident as logged in the 'Accident and Incident report' which was completed by the day nurse, who arrived approximately 90 minutes after the incident occurred, and who reported that Patient F was on the floor. Therefore, it was satisfied that on or around 18 April

2020, on becoming aware that Patient F was on the floor, Miss Ayo-Adesanya did not assist Colleague 3 in getting the patient off the floor.

Accordingly, the panel finds charge 35.1 proved.

Charge 35 (35.2.1, 35.2.2, 35.2.3, 35.2.5 and 35.2.6)

> *"35. On or around 18 April 2020, on becoming aware that Patient F was on the floor:*
>
> *35.2 did not complete one or more of the following checks:*
>
> *35.2.1 initial observation;*
> *35.2.2 neurological observation;*
> *35.2.3 assess them for bruising or fractures;*
> *35.2.5 complete an accident and incident report form;*
> *35.2.6 devise a plan to prevent future occurrences."*

These charges are found proved.

In reaching this decision, the panel took into account all the documentary and witness evidence it considered in charge 35 (35.1). The panel considered all the charges in 35 (35.2) individually at first, and then collectively as these were inextricably linked.

The panel first considered Colleague 3's evidence that Miss Ayo-Adesanya *"walked away"* and *"did not even do a physical check of Patient F to see if he had any injuries, nor did she take any observations e.g., his pulse etc".*

To determine whether Miss Ayo-Adesanya had indeed failed in her professional duty as a nurse, the panel first took account of written and oral evidence from Witness 14, which expanded on what she, as a General Manager, would have expected from

Miss Ayo-Adesanya, in her role as a nurse, after being informed that Patient F was on the floor:

> *"I produce the Accident and Incident report for this incident and Patient F progress note for this incident, completed by the day nurse who came on shift after Bukola, in which it says Patient F was found on the floor…according to the Falls Policy that was in place at the time…if Colleague 3 had told Bukola about Patient F being on the floor before the day nurse arrived then Bukola should have: completed an initial observation, neurological observations, and assessment of Patient F for bruising or fractures. She also should have checked Patient F surroundings for safety, completed an Accident and Incident report, carried out regular observations, informed Patient F's next of kin and provided guidance to the carers on what to do for Patient F.*
> *…*
> *These checks are important for the staff to highlight any abnormalities arising consequent to the fall, to ensure the wellbeing of the patient. Bukola would have known to do this because she is a Registered Nurse. She had also received an induction therefore known or ought to have known about the Home's Falls Policy.*
>
> *There is no entry on Patient F's progress notes regarding a fall incident during Bukola's shift. On the wellbeing check, an entry was noted that at 07.00 hours Patient F was found lying on the floor. Patient F observations were completed by the day nurse. There is no evidence of Bukola monitoring or undertaking any other intervention.*
>
> *As part of the assessment Bukola should have undertaken, she should have devised a plan to prevent future occurrences, as the day nurse did."*

The panel then carefully considered Patient F's care plans. It noted that the care plan was specific in requiring staff to *"record in falls diary if Patient F will have a fall, complete incident report and notify NOK"* and *"after falls staff should update the risk*

assessment". It was satisfied that this was aligned with the expectations Witness 14 outlined above. It also noted that Miss Ayo-Adesanya would have had sight of these care plans.

The panel also had regard to the 'Falls Policy 2017' which was in place at Winchester House at the time and, in particular, the flowchart of procedure following a fall or on finding someone on the floor which sets out *'immediate actions'* for *'trained nurse/senior member of staff must carry out a full examination'*. The panel was satisfied that the instructions shown on the flowchart support the account given in Witness 14's evidence of what was to be expected of Miss Ayo-Adesanya, as a nurse, upon being notified by Colleague 3 that Patient F was on the floor.

The panel was satisfied that it was the responsibility of Miss Ayo-Adesanya to undertake the checks set out in charges 3.2.1 to 3.2.6. It was also satisfied from the evidence of Colleague 3 and Witness 14 that the checks were not completed by Miss Ayo-Adesanya (but instead by the day nurse) and that these accounts were consistent and could be relied on. The panel had no documentary evidence before it to suggest otherwise.

Therefore, the panel found that it was probable that Miss Ayo-Adesanya did not complete checks, namely an initial observation, a neurological observation, an assessment for bruising or fractures, an accident and incident report form nor devise a plan to prevent future occurrences, as required.

Accordingly, the panel finds charges 35.2.1, 35.2.2, 35.2.3, 35.2.5 and 35.2.6 proved.

Charge 35 (35.2.4)

> *"35. On or around 18 April 2020, on becoming aware that Patient F was on the floor:*
>
> *35.2 did not complete one or more of the following checks:*

35.2.4 checked their surroundings for safety;"

This charge is found NOT proved.

In reaching this decision, the panel referred back to all the documentary and witness evidence it considered in the charges above, including the statements of Colleague 3 and Witness 14, notably, Patient F's care plans and the Home's 'Falls Policy 2017' document which was in place at the time of the incident.

The panel was satisfied, on the basis of the evidence before it, that it was part of Miss Ayo-Adesanya's responsibility to undertake checks upon becoming aware that Patient F was on the floor. This included a duty to check Patient F's surroundings for safety.

The panel considered that the evidence of Colleague 3, whom it found to be credible and reliable, stated that when she went to call Miss Ayo-Adesanya from the nurses' office, Miss Ayo-Adesanya came to the room with her to help Patient F off the floor. Further, Colleague 3 stated that:

> *"Bukky told me that I should make Patient comfortable on the floor by getting a sheet underneath him, covering him with a blanket and handing him over to the day staff that were due to start work at 08.00 hours."*

The panel was satisfied that there was evidence before it to suggest that Miss Ayo-Adesanya did check Patient F's surroundings for safety as she went to the room where Patient F was and later provided Colleague 3 with instructions about what to do until the patient can be handed over to the day nurse.

Accordingly, the panel finds charge 35.2.4 not proved.

Charge 36

"36. On one or more occasions refused to assist Colleague 3 with the personal care of one or more residents."

This charge is found proved.

The panel first considered the evidence of Colleague 3 in relation to this charge. She stated that:

"In my experience, nurses always helped the carers with the personal care of residents whenever we needed a hand...That was not the case with Bukky…

Whenever I asked Bukky for help, her standard response was 'I'm a nurse, not a carer' and she would then walk off. Other times she would say she would in a minute, or once she had finished giving medication, but she would walk away and never come back. There were a few times when I insisted that I needed her help, and she came with me but would just stand there. When I asked her not to stand there and to actually help, she would walk off."

The panel also heard oral evidence from Colleague 3 stating that:

"even if an emergency buzzer went off, [Miss Ayo-Adesanya] wouldn't have wouldn't have come", "she wasn't interested" and *"didn't feel she was there to support anybody…left [Colleague 3] all alone on [her] own"*

The panel found this to be consistent with her witness statement, and her contemporaneous account during the investigatory meeting with Witness 14 on 18 December 2020.

Whilst this charge relates specifically to Colleague 3, the panel took account of evidence heard from its earlier consideration about Miss Ayo-Adesanya's exchange with Colleague 2 where she refused to assist a resident with personal care and left abruptly during handover.

The panel took account of further supporting evidence from Colleague 4' local statement on 18 December 2020, which stated that Miss Ayo-Adesanya *"does nothing, she don't even help"* and *"made up so many excuses why she wouldn't help".*

The panel noted that the wording of the charge is *'on one or more occasions'*. Thus, the charge would be met if the panel found on the balance of probabilities that Miss Ayo-Adesanya refused to assist Colleague 3 with personal care of residents, at least once. On the basis of Colleague 3's evidence, the panel concluded that Miss Ayo-Adesanya had on one or more occasions refused to assist her with the personal care of one or more residents.

Accordingly, the panel finds charge 36 proved.

Charge 37

> *"37. On an unknown date in June 2020 did not help Colleague 4 with an incident with Patient E."*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 4, which stated:

> *"…I remember this incident very well. It happened in my first week. The resident's name was ('Patient E'). He was elderly and had dementia.*
>
> *I had gone to check on Patient E with my colleague Sharna…on entering his room, I found that Patient had soiled himself; there was urine and faeces everywhere e.g., on the floor and in his bed. The room also smelled really bad. Patient E was very aggressive at times; he used to punch us. Sharna and I tried to change Patient E but when we got close to him he would shout*

and lash out., trying to hit us I decided that we needed three people to change Patient E; an extra person to distract him or try and calm him whilst Sharna and I changed him.

I went to get Bukola, who was in the office. I told her that we needed help changing Patient E. Bukola came with me to his room. When she saw Patient E trying to hit me and Sharna, Bukola told us to leave him for the day shift staff to deal with because she would not help if he was behaving that way. I told her that we could not leave him in that state, but Bukola insisted. I cannot remember exactly what she said but she was very rude to me. I remember her saying that I needed to listen to her and leave Patient E. I cried from how rude she was being to me.

Bukola left us and Sharna and I continued to try and change Patient E. It was not working so I went to get another carer, who came and with her help we were ultimately able to calm Patient E down enough for us to change him."

The panel also heard oral evidence from Colleague 4, which it found to be consistent with her witness statement above. It noted that this specific incident *"stuck in her mind"* and she was clearly able to recall the events.

The panel also found Colleague 4's evidence to be consistent with other contemporaneous evidence, namely her local statement dated 18 December 2020, where she stated that:

"…[Miss Ayo-Adesanya] told me to leave Patient E as he was soaking wet, she said leave for the day staff…Patient E was agitated, asked Bukola to help us and she said leave him, she's not going to help if he's like that…"

On the basis that it was consistent and corroborative with evidence from Colleague 3, the panel was satisfied that Colleague 4's evidence was credible and could be relied upon. The panel had no response from Miss Ayo-Adesanya to contest the

charge. It therefore concluded, on the balance of probabilities, that it was more likely than not that on an unknown date around June 2020, she did not help Colleague 4 with an incident with Patient E.

Charge 38

> *"38. Did not disclose to Winchester House Care Home that you were under investigation by the NMC."*

This charge is found NOT proved.

In reaching this decision, the panel took careful account of the evidence of Witness 14:

> *"I was unaware that Bukola was subject to an ongoing NMC fitness to practise investigation. The first I knew of the NMC's involvement was when the Investigator got in touch to request an employment reference. When I asked Bukola about the NMC investigation afterwards, she said to me that she had told the previous manager that she was under investigation however, I've reviewed the notes for Bukola's interview and there's nothing noted there to suggest that Bukola disclosed the fitness to practise investigation to the previous manager. When I challenged Bukola about why she hadn't shared this information with me directly, she seemed to turn it around and said that because I was new to my post, I should have been asking each of the staff members whether there was anything that they wanted to disclose. I made it very clear to Bukola that this wasn't the case. I explained that I've got 150+ staff and that it would be impossible for me to do that for each staff member. I told Bukola very clearly that she should have asked for a confidential meeting and she should have disclosed the existence of the NMC investigation to me directly."*

In order to assess whether or not there was a requirement for Miss Ayo-Adesanya to disclose that she was under investigation by the NMC, the panel looked closely at Miss Ayo-Adesanya's job application form dated 12 June 2019 and the notes from her employment interview dated 14 June 2019.

The panel noted that on Miss Ayo-Adesanya's application form, there was a section at the 'Declaration' stage, which required her to confirm the following:

> *"You must advise the company at interview if you have any restrictions in practising as a nurse, or are subject to an investigation by the NMC"*

It determined that whilst there was a burden on Miss Ayo-Adesanya to have disclosed that she was under investigation by the NMC, there was also some responsibility from the employer to 'verify' whether her declaration on her application form was correct. It is Miss Ayo-Adesanya's contention (her written response) that she did disclose information about NMC proceedings to her previous manager.

As a result of the disputed nature of the evidence the panel heard and the lack of any direct evidence from the person who conducted the interview, it determined that the NMC has failed to discharge its burden of proof in relation to this charge.

Accordingly, the panel finds charge 38 not proved.

Charge 39

> *"39. Your actions at charge 38 were dishonest in that you sought to conceal the fact that you were under investigation by the NMC in order to gain employment."*

This charge is found NOT proved.

The panel noted that this charge was inextricably linked to charge 38. It referred to its findings and reasoning above and determined that, having found charge 38 not proved, it follows that this charge could also not be proved as the NMC had not discharged its burden of proof. Accordingly, the panel finds charge 39 not proved.

Charge 40

> *"40. Provided Individual 3's details as a referee, stating that he was your manager when applying to one or more of the following organisations:*
>
> *a) Barchester healthcare*
> *b) Medicure Professionals*
> *c) Medics Pro"*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all the documentary and witness evidence before it. The panel considered the charges individually at first, and then collectively.

The panel first established whether Individual 3's details were provided by Miss Ayo-Adesanya as a referee was someone who she had identified as her former line manager. In reaching its conclusion, it first considered the evidence of Witness 18, who stated that in Miss Ayo-Adesanya's job application form on 18 June 2019:

> *"…she provided two clinical references i.e., a Individual 3 and a Individual 4. I confirm that references were received from these two individuals for the registrant. Clinical references must come from nurses who are in a managerial position..."*

The panel also had sight of the employment reference section on Miss Ayo-Adesanya's job application form and was satisfied that she had provided the details of Individual 3 as *'Clinical Reference 1'* and entered his role as her *'Manager'*.

The panel then turned to the evidence about what Individual 3's role was at ELFT. It had particular regard to the evidence of Witness 20, who stated that:

> *"I can confirm that we had a member of staff working for ELFT named Individual 3. He was employed between 7 March 2018 and April 2021. Individual 3 was employed as a Band 6 Information Analyst within our Performance Team. This is a non-clinical role. I have reviewed Individual 3's personal file and can confirm that he holds a BSC qualification in Finance which he obtained in Nigeria in 1995. I have also reviewed his employment history with ELFT and can confirm that he has been employed as a Data Analyst and an Information Manager. None of these roles are clinical and he has not held the role of Team Leader.*
>
> *In his role, Individual 3 had no line management responsibility for any of the Nursing Staff. He was certainly not Miss Ayo-Adesanya's Line Manager."*

The panel also had sight of the email correspondence between an NMC investigator and a Chief Nurse at ELFT, dated 4 March 2021, which affirmed that ELFT had *"looked at the refer* [sic] *and have a member of staff called [Individual 3] is Information Analyst Band 6 who is in Performance team."*

The panel was satisfied that the written and oral evidence of Witnesses 18 and 20 was consistent and corroborative with their contemporaneous accounts. It was also satisfied that Individual 3 was an Information Analyst, who held no clinical leadership responsibilities and was not Miss Ayo-Adesanya's manager, as she stated.

The panel noted that Witness 20 had outlined in sufficient detail the standard process for collecting references:

"In a normal Ward setting, a Registered Nurse's line manager would usually be the Ward Manager, who is also a Registered Nurse. In Community settings, the Line Manager will be a clinician but they don't necessarily have to be a Registered Nurse…the Line Manager would always be someone with a clinical background, whether that is in nursing or a different discipline".

Whilst the panel was mindful that the evidence before it was more specifically in relation to 'Medicure Professionals', it also noted that the charge stated *'one or more of the following organisations'*. Therefore, a finding for one of the organisations listed in charge 40 is sufficient to find the charge proved in its entirety.

Accordingly, the panel finds charge 40 proved in its entirety.

Charge 41

"41. Your actions at any or all of charge 40 was dishonest in that you stated that Individual 3 had been your line manager when you knew that they were not."

This charge is found proved.

In reaching this decision, the panel took into account its considerations at charge 40 above as the two are inextricably linked. The panel was satisfied that, on the balance of probabilities, Miss Ayo-Adesanya must have known that Individual 3 was not her 'Manager' and that he did not hold the qualifications or any clinical responsibility to satisfy the requirements of a 'clinical reference'. It determined that an informed and reasonable person would find Miss Ayo-Adesanya's actions to be dishonest and find that she had manufactured a professional identity in order to procure a fake employer reference.

Accordingly, the panel finds charge 41 proved.

Charge 42

"42. Provided Individual 4's details as a referee, stating that they were your line manager when applying to one or more of the following organisations:

a) Barchester
b) Medicure Professionals"

This charge is found proved in its entirety.

In reaching this decision, the panel considered the charges individually at first, and then collectively.

To establish firstly whether Individual 4's details were provided by Miss Ayo-Adesanya as a referee and as her former line manager, the panel considered the evidence of Witness 18. This stated that in Miss Ayo-Adesanya's job application form on 18 June 2019:

"…she provided two clinical references i.e., a Individual 3 and a Individual 4. I confirm that references were received from these two individuals for the registrant. Clinical references must come from nurses who are in a managerial position..."

The panel had sight of the employment reference section on Miss Ayo-Adesanya's job application form and was satisfied that she had provided the details of Individual 4 as *'Clinical Reference 2'* and had entered her role as her *'Manager'*. It also had sight of the references provided by Individual 4 to Medicure Professionals on 3 July 2019 and Barchester Healthcare on 11 July 2019.

Therefore, the panel concluded that there was cogent and compelling evidence to suggest that Miss Ayo-Adesanya had provided Individual 4's details as a referee,

stating that she was her line manager when applying to Barchester and Medicure Professionals when clearly she was not.

Accordingly, the panel finds charge 42 proved.

Charge 43

> *"43. Your actions at any or all of charge 42 was dishonest in that you stated that Individual 4 was your line manager when you knew that they were not."*

This charge is found proved.

In reaching this decision, the panel took into account its considerations at charge 42 above as the two are inextricably linked.

The panel had particular regard to the evidence about Individual 4's role. It took account of the evidence of Witness 17, which stated that:

> *"I can confirm that Individual 4 was an employee of Cygnet Healthcare between 7 May 2019 and 14 November 20. Individual 4 was employed as the Acting Clinical Service Manager for Cygnet Hospital Beckton on a full-time, fixed term contract. Individual 4 was offered and accepted a permanent contract on 23 September 2019. Individual 4's position was a clinical role, similar to that of a Ward Manager in an NHS Hospital and, by virtue of her position, Individual 4 had line Manager had line manager responsibility for all nursing staff at Cygnet Hospital Beckton.*
>
> *In her role Individual 4 had no line management responsibility for Miss Ayo-Adesanya. They were not employed at the same location and therefore they would not have worked together There is also a discrepancy in the dates when they both worked for Cygnet Healthcare: Miss Ayo-Adesanya's*

employment ceased on 20 October 2017 whereas Individual 4 did not commence her position until 7 May 2019. On both of the references I have been asked to consider Individual 4 has indicated that she was Miss Ayo-Adesanya's team manager. This is simply not correct."

The panel was satisfied that the written and oral evidence of Witness 17 and Witness 18 were consistent and corroborative with the contemporaneous documentary evidence, which identified that Individual 4 was not Miss Ayo-Adesanya's manager at the time of her application.

The panel also noted that Witness 17 outlined the standard process for references at Cygnet Healthcare:

"It is policy within Cygnet Healthcare for all references to be completed by Human Resources"

Therefore, having had sight of the references provided by Individual 4 to Medicure Professionals on 3 July 2019 and Barchester Healthcare on 11 July 2019, which were contrary to the policy set out by Witness 17, the panel concluded that Individual 4 was not Miss Ayo-Adesanya's 'Manager' and Miss Ayo-Adesanya must have known that her actions in procuring a reference were dishonest.

The panel determined that this would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel finds charge 43 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Ayo-Adesanya'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 Ayo-Adesanya's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Malik referred the panel 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.'*

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

He further submitted that the following standards where Miss Ayo-Adesanya's actions amounted to misconduct. He referred the panel to 1.1, 1.2, 1.4, 2.1, 2.6, 8.1, 8.2, 8.5, 20.1, 20.2 and 20.5 of the Code.

Mr Malik submitted that Miss Ayo-Adesanya's acts, fell short of the standards set out in The Code. He submitted that Ms Ayo-Adesanya acted inappropriately by giving

the impression to Patient B that she was calling the police when in fact she was not. He submitted that she intended to cause Patient B fear, alarm and distress. Mr Malik reminded the panel that Miss Ayo-Adesanya attempted to administer an IM injection to Patient B in the bedroom which was not appropriate and against Trust policy. He submitted that Miss Ayo-Adesanya not only put herself at risk but her colleagues and the patient.

Mr Malik submitted that the actions by Miss Ayo-Adesanya are failings directly related to her clinical practice. He reminded the panel that Miss Ayo-Adesanya claimed she had worked shifts and attended training when she had not; that she used her mobile phone despite being aware that she was not supposed to use it at work and did not carry out patient observations which she was assigned to do. Miss Ayo-Adesanya left patients to dispense their own medication without supervision as well as slept whilst on duty.

Mr Malik submitted that Miss Ayo-Adesanya's actions demonstrate a pattern of sustained dishonest and unprofessional behaviour. He submitted that this can be difficult to remediate.

Submissions on impairment

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

Mr Malik submitted that all four limbs of Grant are engaged by the circumstances of this case. He submitted that Miss Ayo-Adesanya's actions have brought the nursing profession into disrepute, and that she has breached fundamental tenets of the nursing profession by failing to promote professionalism, trust, and acting in a

thoroughly dishonest manner. He submitted that the NMC considers that there is a continuing risk to both public protection and the wider public interest due to Miss Ayo-Adesanya's actions being directly linked to her clinical practice and dishonesty in this case.

Mr Malik submitted that Miss Ayo-Adesanya's behaviour raises fundamental concerns about her attitude as a registered professional and that she failed to address and put the issues right. He submitted that this demonstrates serious breaches of trust and abuse of authority and fundamental dishonesty which undermines or completely erodes public trust and confidence in the profession.

Mr Malik submitted that you have not submitted a reflection statement to the panel. He submitted that the concerns have not been remediated and are therefore highly likely to be repeated should Miss Ayo-Adesanya be permitted to practise as a nurse again.

Mr Malik submitted that a finding of impairment is also necessary on public interest grounds in this case. He submitted that the conduct of Miss Ayo-Adesanya has brought the nursing profession into disrepute and served to undermine public confidence and trust in the profession.

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 your actions did fall significantly short of the standards expected of a registered nurse in a number of respects that are detailed

below, and that Miss Ayo-Adesanya's 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 work in partnership with people to make sure you deliver care effectively*
> *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*
>
> ***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*
>
> ***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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

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

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

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

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

In respect of the first set of charges arising at Huntercombe the panel looked at the issues arising from charges 2 and 3. The panel determined that the two charges are closely linked together and were sufficiently serious to amount to misconduct. The panel determined that these actions were intended to cause Patient B alarm and

distress as they were an already vulnerable mental health patient. The panel determined that your actions fell well below the standard expected of a nurse and therefore concluded these charges amount to misconduct.

In respect of charge 8, the panel accepted that Miss Ayo-Adesanya faced exceptionally difficult circumstances during this particular shift, including an increasing agitation amongst some of the young residents with verbal and physical attacks targeted at her. The panel acknowledged that she may have needed to administer an IM in an unsuitable setting because of an emergency. Whilst this was a technical breach of the Trust's policy, which mandated IM's be given in an area with cameras, the panel noted that Miss Ayo-Adesanya made this attempt with multiple staff present. Furthermore, the panel considered that this was a single incident and taking all of these circumstances into account, it did not find misconduct.

In respect of charge 14, the panel determined that this charge was particularly serious. The panel considered that threats of any kind were antithetical to good nursing practice, especially where this is attempted in a hostile manner or with a sense of retribution. The panel found that this was particularly aggravating in a situation with vulnerable service users. Consequently, the panel found that this charge amounted to misconduct.

In respect of charge 15, the panel accepted that you had faced provocation from more than one patient during this shift, including verbal threats and actual physical assaults, but nonetheless concluded that 'finger pointing' was an inappropriate way of communicating with vulnerable mental health patients because it could have a triggering effect on some. Whilst the panel was of the view that this behaviour was certainly suboptimal of what is expected of a registered nurse, when balancing the context, it determined that this charge did not amount to misconduct.

Charges 20(a-c) related to the second setting at Cygnet Hospital Godders Green. The evidence in relation to these charges i.e. false claims for payment for shifts

when she was not present, is strong and compelling. It is the sort of behaviour that Miss Ayo-Adesanya's colleagues would find deplorable and be considered similarly by members of the public. Consequently, the panel determined that all of these charges amount to misconduct.

Charges 22(a-b) are similar in nature and also relate to claims for payment for shifts that Miss Ayo-Adesanya had not undertaken. The panel determined that these charges amounted to being so serious as to constitute misconduct. The panel concluded that she was dishonest in that she did not attend her shifts as set out by her on the stated dates. It also concluded that Miss Ayo-Adesanya did not request annual leave as claimed in her response. The panel considers honesty to be a fundamental tenet of the profession and therefore that a charge of being found to be dishonest falls well below of what is expected of a registered nurse. The panel therefore determined that this charge also constituted misconduct.

In respect of charge 26, the panel noted that Miss Ayo-Adesanya had partly acknowledged in her response, her failure to carry out patient observations when assigned to do so. However, the panel found that this failure was so serious as to amount to misconduct due to the high risk of harm presented to patients in omitting observations.

In respect of charges 27(a-b), the panel determined that patients, on one or more than one occasion, were left to dispense their medication without supervision. This posed risks for their own safety as well as that of other patients and staff. The impact of these actions was exacerbated in a mental healthcare setting. Accordingly, the panel found that this charge also constituted misconduct.

In respect of charge 28, the facts found proved here are serious, relating to sleeping whilst on a shift at work. The panel considered that in doing so, Miss Ayo-Adesanya had put patients and staff at risk of harm, and her behaviour fell well below the standards expected of a registered nurse. Consequently, the panel found that this charge constituted misconduct.

Charge 29 relates to attitudinal concerns and Miss Ayo-Adesanya's professional conduct when requested or required to provide personal care to residents under her care. The panel determined that she failed to display good nursing practice, claiming on more than one occasion that this was not part of her professional duties. The panel accepts that whilst may not have been stated explicitly in Miss Ayo-Adesanya's job description, it is something that ordinary members of the public, fellow practitioners and patients would and should reasonably expect a registered nurse to assist patients with.

Charge 30 relates to the comments that Miss Ayo-Adesanya made in the previous charge being overheard by a vulnerable elderly patient. The panel considered that these comments could have caused potential distress to her and other patients. Furthermore, the panel bore in mind Witness 14's oral evidence in which she stated Miss Ayo-Adesanya's comment about not participating in residents personal care had made her feel undermined and inferior. The panel therefore found that this charge constituted misconduct.

In respect of charge 31, the panel took into account Miss Ayo-Adesanya's response in which she had expressed that she had no choice but to leave [PRIVATE] and that the arrangements were not to her satisfaction. However, Miss Ayo-Adesanya left her shift and the Home abruptly without authorisation from her manager. Whilst having some empathy for the situation she found herself in on this unit, it is apparent that [PRIVATE]. Her unauthorised and sudden departure from the unit is a serious issue as it could have caused difficulties and posed a risk to patients' and colleagues' safety. Consequently, the panel determined that in withdrawing herself from the shift without managerial approval, that this charge constituted misconduct.

In respect of charge 32, this is the second care setting in which the same set of concerns were reported by colleagues about the inappropriate use of a mobile phone whilst on duty at work. The panel was of the view that Miss Ayo-Adesanya had displayed a pattern of behaviour in which she used her mobile phone on multiple occasions during her shift without proper regard to patient safety. This posed risks to

patients and colleagues as you were not focused on your work. The panel therefore found that this charge constituted misconduct.

Charge 34 is a repetition of an earlier charge (28) relating to sleeping whilst on duty at work, but at a different setting. The panel found that Miss Ayo-Adesanya has displayed a casual attitude to this pattern of behaviour where she was clearly not alert and awake at work and therefore could not be available to her colleagues or her patients. Therefore, as with charge 28, the panel found that this charge constituted misconduct.

In respect of charge 35, the panel determined that failing to come to the assistance of a patient who had fallen, was an extremely serious matter and a fundamental departure from Miss Ayo-Adesanya's professional duty as a registered nurse. The panel found that this charge constituted misconduct.

The panel next turned its attention to charges 35.1 to 35.2.6 and considered these charges together. It determined that all of these charges amounted to misconduct. It took into account Miss Ayo-Adesanya's failure to assist, clinically assess, risk assess or document any care plan for Patient E. These omissions posed a high risk of harm to this patient and is incompatible with good nursing practice. The panel therefore determined that these charges amounted to misconduct.

The concerns and circumstances relating to charge 36 are similar in nature to those heard by the panel in relation to charge 29 in that they relate to the failure of Miss Ayo-Adesanya's to provide person centred care. Instead, she displayed a rather disdainful attitude to the provision of personal care to patients. This is not what would be expected of the nursing profession. Therefore, for the same reasons set out earlier, the panel finds that this charge amounted to misconduct.

In respect of the issues and concerns raised in charge 37 which relate to Miss Ayo-Adesanya's unwillingness to help a colleague with a patient who was in need of assistance. The panel noted the nature of the concerns and risks and how similar

they were to those set out in charge 35 in which she also refused to assist a colleague with the care of a patient. The panel therefore determined that this charge also amounted to misconduct.

The final set of charges relate to the procurement and presentation of professional references under false pretences. The panel considered this to be a serious matter that goes to the heart of honesty and integrity and the reputation of the nursing profession. The panel took these charges collectively and found that it amounted to serious misconduct. The falsification of references is a serious matter and the panel therefore concluded that this also amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of her misconduct, Miss Ayo-Adesanya's fitness to practise is currently impaired.

In making its decision the panel had regard to the *NMC Guidance on Impairment DMA-1.*

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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

The panel has found that Miss Ayo-Adeysanya's misconduct took place over three different care settings and was sustained over a period of time. There was a pattern of misconduct that included repeated acts of dishonesty.

The panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution, or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

When considering the first limb of Grant, the panel concluded through multiple examples given below, how in different care settings Miss Ayo-Adesanya has acted in the past so as to put patients at unwarranted risk of harm.

The panel found that Miss Ayo-Adesanya's actions in claiming to call the police were intended to cause fear, alarm, and distress to a vulnerable patient. It also found that she threatened another vulnerable patient with an IM injection as retribution, which would place that patient at risk of emotional harm.

The panel considered that by repeatedly using her mobile phone on duty when she knew it was in contravention of policy, sleeping on duty on more than one occasion and leaving a shift without authorisation Miss Ayo-Adesanya's behaviour fell far below that which is expected of a registered nurse. She placed patients and her colleagues at unwarranted risk of harm by not being available to them and not focusing on her duties as a registered nurse.

The panel also found that Miss Ayo-Adesanya failed to complete observations on a patient when these observations were assigned to her. This placed the patient at risk that any change or deterioration in their health would not be observed or recorded. In a separate incident she was made aware that a patient was on the floor, and she did not assist her colleague, carry out observations/clinical assessments required by the relevant *Falls Policy* to determine whether the patient had come to any harm, or take any other actions to protect the patient from any further unwarranted risk of harm. There was evidence of repetition of this, when for example, the panel found that in another incident Miss Ayo-Adesanya did not come forward to assist a colleague with a patient reported to her as being potentially violent, placing both her colleagues and the patient at risk of harm.

The panel considered that limbs b), c) and d) of Grant are also engaged in this case. Miss Ayo-Adesanya has in the past brought the profession into disrepute, breached fundamental tenets of the profession, and has acted dishonestly. Her misconduct was wide-ranging and sustained over several months in multiple care settings. She failed to provide safe and effective care to patients and to act with honesty and integrity. In refusing to assist a patient who was lying on the floor, to assist colleagues with the care needs of patients and a colleague with a potentially violent

patient, the panel determined that Miss Ayo-Adesanya displayed a disdainful attitude to the care of her patients and the welfare of her colleagues.

The panel also found that Miss Ayo-Adesanya's actions demonstrated a pattern of sustained dishonest behaviour. Her dishonesty was linked to her professional practice and carried out for her actual or potential financial gain in claiming payment for training which she had not undertaken, for hours she had not worked, and for falsifying references to obtain employment.

Having concluded that all 4 limbs of Grant were engaged in the past the panel went on to consider the future risk of such behaviour being repeated and whether Miss Ayo-Adesanya's fitness to practise is currently impaired.

With regard to future risk, the panel considered the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) as to:

(i) whether the concerns are easily remediable;
(ii) whether they have in fact been remedied; and
(iii) whether they are highly unlikely to be repeated

The panel throughout these proceedings has sought to engage with Miss Ayo-Adesanya, informing her of developments at all key stages. This included sharing determinations once reached, in order to give her the opportunity to submit written submissions by way of reflection that might assist the panel's decision making. It was conscious of the potential disadvantage to her arising from the fact that the panel was proceeding in her absence. She did not respond.

The panel was of the view that Miss Ayo-Adesanya's repeated misconduct, particularly her disregard for colleagues and patients and her dishonesty, displayed serious attitudinal concerns that are difficult to remediate.

The panel went on to consider the extent to which Miss Ayo-Adesanya has reflected upon events and provided evidence of her insight and strengthened practice as has already been touched upon. Miss Ayo-Adesanya has not engaged with this fitness to practise hearing, apart from the first two days where she requested an adjournment. The panel did however have access to the previous written reflections from Miss Ayo-Adesanya, dated 12 February 2021 and 26 May 2021, and has taken these into account throughout this hearing.

The panel noted the following from the 12 February 2021 reflection on the incident involving her leaving a shift without authorisation:

> *"However, reflecting on the night in question, I can see that I have let my colleagues down by leaving the home. By leaving, the team were a nurse short and this could have compromised resident care, something which I am very sorry for. It is vital that healthcare staff work as a team and support each other.*
> *[…]*
> *Further to the above, I have reflected on the effect that my absence had on the residents. By not having a nurse there to work when there should have been, I could have risks harm or lack of care to the residents. I am also sorry to my employer. [PRIVATE], having one nurse is better than not having any nurse at all. I know that my decision was not correct and my emotions contributed but if I came across a similar situation again, I would try to think clearly and find a solution with my management to ensure that patients/residents are safe and looked after."*

The panel took into account that in this reflection Miss Ayo-Adesanya demonstrated some awareness of the impact of her actions on others in relation to this one incident, apologised for her behaviour and expressed how she might do things differently in the future if faced with similar circumstances.

However, the panel received no further evidence of reflection or insight, despite the number of incidents, charges found proved in multiple care settings, and findings of

misconduct. It therefore concluded that Miss Ayo-Adesanya's insight into her actions is very limited. The panel has no evidence before it of strengthened practice. In the absence of sufficient evidence of insight, no evidence of strengthened practice and given the difficulty in remediating the concerns, the panel concluded that there is a significant risk of repetition and a risk of significant harm to patients and the public in the future.

The panel bore in mind 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 as Miss Ayo-Adesanya continues to present a risk to patients and the public then a finding of current impairment is required to protect, promote, and maintain the health, safety, and well-being of the public and patients. The panel also concluded that public confidence in the profession and the NMC as its regulator would be seriously undermined if a finding of impairment were not made in this case given the serious, wide-ranging, and sustained nature of the misconduct across three separate care settings, including her repeated dishonesty. A finding of impairment is also required to uphold proper professional standards. Therefore, the panel finds that Miss Ayo-Adesanya's fitness to practise is also impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Ade-Adesanya's fitness to practise is currently impaired on both the grounds of public protection and the wider public interest.

Sanction

The panel having considered this case very carefully has decided to make a striking-off order. It directs the registrar to strike Miss Ayo-Adesanya off the register. The

effect of this order is that the NMC register will show that Miss Ayo-Adesanya has been struck-off the register.

In reaching this decision, the panel has had careful regard to all the evidence that has been adduced in this case and had regard to the Sanctions Guidance (SG) by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, dated 7 March 2024, the NMC had advised Miss Ayo-Adesanya that it would seek the imposition of a strike-off order if it found Miss Ayo-Adesanya's fitness to practise currently impaired.

Mr Malik submitted that a striking-off order is the most appropriate and proportionate sanction. He referred the panel to the NMC Guidance SAN-1. Mr Malik submitted that the panel should have consideration to the aggravating features which includes dishonesty directly relating to Miss Ayo-Adesanya's clinical practice, sustained dishonest conduct which can be acknowledged as being difficult to put right, attitudinal concerns, multiple failings over a period of time over three separate employers, and limited remediation insight and remorse.

Mr Malik submitted that there was only one mitigating feature in this case, namely, the fact that Miss Ayo-Adesanya had briefly engaged with the NMC at the start of this hearing.

Mr Malik submitted that when considering the sanction in the order of seriousness, taking no action or a caution order would not be appropriate consideration given the seriousness of this case. He submitted that dishonesty is a serious matter and that it would not be proportionate nor in the public interest to take no further action. Mr Malik submitted that this case is not at the lower end of the spectrum of impaired fitness to practice.

Mr Malik referred the panel to the NMC Guidance SAN-3. He submitted that when considering conditions of practice, it is considered appropriate where the concerns can be easily remediated and when workable conditions could be identified in order to protect the public and satisfy the wider public interest concerns. He submitted that in this case, there is evidence of direct harm and potential risk of harm to patients as a result of Miss Ayo-Adesanya's misconduct. Mr Malik submitted that Miss Ayo-Adesanya demonstrated a pattern of sustained dishonest behaviour which can be linked to her professional practice.

Mr Malik submitted that with regard to the dishonesty charges there was direct personal financial gain in claiming payments and/or training in which Miss Ayo-Adesanya had not worked and that she had falsified references to obtain employment. He submitted that in relation to the charges of dishonesty, there was repeated misconduct. Mr Malik submitted that her dishonesty was difficult to remediate and that there was significant evidence of deep-seated attitudinal concerns.

Mr Malik submitted that in the absence of sufficient evidence of insight, and given the difficulty in remediating the concerns, there remains a significant risk of repetition and a significant risk of harm to patients and the public.

Mr Malik submitted that Miss Ayo-Adesanya had displayed dishonest conduct over a sustained period of time and that she had breached the professional duty of candour in three different care settings. He submitted that there was a pattern of misconduct that included repeated acts of dishonesty.

Mr Malik submitted that a conditions of practice order would therefore not be appropriate as there are not identifiable areas of Miss Ayo-Adesanya's practice that are in need of assessment and training. He submitted that the matters in this case are too serious and that there are no workable conditions that could be formulated to deal with the regulatory concerns.

Mr Malik next referred the panel to the NMC Guidance SAN-3d, '*Suspension order*.' This indicates that a suspension order is only appropriate where the misconduct isn't fundamentally incompatible with the nurse, midwife or nursing associate continuing to be a registered professional. Mr Malik referred the panel to a checklist that suggests a suspension may be appropriate in circumstances where there is:

- A single instance of misconduct, but where a lesser sanction is not sufficient.
- No evidence of harmful deep-seated personality or attitudinal problems.
- No evidence of repetition of behaviour since the incident.
- And the committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour.

Mr Malik submitted that in this case, the concerns raised are serious and highlight a deep-seated attitudinal issue. He further submitted that the concerns raised were not an isolated one-off event and that Miss Ayo-Adesanya's insight is very limited. Mr Malik submitted that there remains a risk of repetition. He submitted that a suspension order is not appropriate in this case.

Mr Malik submitted that Miss Ayo-Adesanya demonstrated some awareness of the impact of her actions on others in relation to one incident. There is an account to this effect in her response bundle of February 2021. He submitted that in this response she was apologetic in her behaviour and that she expressed how she might do things differently in the future if faced with similar circumstances.

Mr Malik further submitted that Miss Ayo-Adesanya had the opportunity at the start of the hearing to admit the dishonesty charges but failed to do so. Mr Malik submitted that she has presented no clear insight and that the findings of misconduct raise fundamental concerns about her professionalism.

Mr Malik submitted that the trust and confidence in the profession can only be maintained by the imposition of a striking-off order. He referred the panel to the NMC

Guidance SAN-3e. He submitted that Miss Ayo-Adesanya's actions were a significant departure from the standards expected of a registered nurse and that it would be fundamentally incompatible with her remaining on the register.

Mr Malik submitted that allowing Miss Ayo-Adesanya to continue practising would also undermine public confidence in the profession and the NMC as a regulatory body. Mr Malik concluded by saying that the NMC believes a striking off order is the most appropriate and proportionate sanction in this case.

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

Decision and reasons on sanction

Having found Miss Ayo-Adesanya'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. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Limited insight and reflection in relation to the scale of the charges found proved and the misconduct identified
- Pattern of misconduct which was sustained over a period of time over 3 different care settings
- Misconduct which caused actual harm to vulnerable patients, caused further risk of harm to those patients and placed risks upon fellow colleagues and staff.
- Sustained dishonesty motivated by financial gain across multiple care settings and relating to her professional practice.

The panel acknowledged that Miss Ayo-Adesanya had shown a willingness to engage at the beginning of the hearing. It also took into account the following mitigating features:

- Limited remorse and reflections in respect of a single incident (in Miss Ayo-Adesanya's response dated February 2021) in which she expressed regret and demonstrated some awareness of how she would act differently in the future.
- The panel acknowledges the difficult set of circumstances at Huntercombe PICU in which Miss Ayo-Adesanya faced verbal and physical assaults.
- The panel had empathy towards [PRIVATE] and the event that occurred on the night in which she may have acted irrationally when she decided to leave the Unit and Home without authorisation.

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 determined that taking no action would neither protect the public nor serve the public interest because of the high risk of repetition of harm in future. The panel therefore concluded 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 Miss Ayo-Adesanya'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 determined that Miss Ayo-Adesanya's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel therefore 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 Ayo-Adesanya's registration would be a sufficient and appropriate response. The panel considered the NMC Guidance SAN-3c. In this case it was clear that Miss Ayo-Adesanya displayed behavioural and attitudinal concerns that arose in multiple settings over a period of time. The panel had also determined that Miss Ayo-Adesanya displayed a disdainful attitude towards providing personal care. As a result, it concluded that there are no practical or workable conditions that could be formulated, given the nature of the misconduct in this case.

The panel also determined that Miss Ayo-Adesanya's pattern of misconduct is so serious that in the absence of deep reflection, insight and evidence of strengthened practice it was not something that could be addressed adequately simply through training.

The panel therefore concluded that the placing of conditions on Miss Ayo-Adesanya's registration would not adequately address the seriousness of concerns in this case, nor would it protect the public or serve to uphold the reputations of the profession or the regulator.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel determined that this is not an isolated incident but rather one in which Miss Ayo-Adesanya has demonstrated a repeated pattern of serious misconduct in multiple care settings over a sustained period of time. Alongside this it has concerns about deep seated and underlying attitudinal concerns. Moreover Miss Ayo-Adesanya's misconduct involved repeated dishonesty. Concerns about her honesty and integrity are not easily addressed or mitigated and pose a significant continuing risk to patients, her colleagues and to the public's perception of the nursing profession. The panel's findings of misconduct arising from dishonesty, notably that Miss Ayo-Adesanya stood to gain financially constitute a serious a breach of trust.

Miss Ayo-Adesanya's conduct, was a significant departure from the standards expected of a registered nurse. The panel determined that her lack of professionalism and pattern of dishonesty were a serious breach of the fundamental tenets of the profession and are fundamentally incompatible with Miss Ayo-Adesanya remaining on the register.

In this particular case, the panel therefore determined that a suspension order would also not be a sufficient, appropriate or proportionate sanction.

Finally, the panel considered a striking-off order, noting in particular the following paragraphs of SAN-3e:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel found Miss Ayo-Adesanya's actions particularly in relation to her intentionally causing fear/alarm and/or distress to a vulnerable young patient, her financially motivated dishonesty, and the dereliction of her duty to assist and assess an elderly resident following a fall were antithetical to nursing practice. All these examples of misconduct raised fundamental questions about her professionalism. The panel decided that public confidence could not be maintained if Miss Ayo-Adesanya remained on the register.

Miss Ayo-Adesanya's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that their findings demonstrate that Miss Ayo-Adesanya's actions were so serious that to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

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

This will be confirmed to Miss Ayo-Adesanya in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, or, if an appeal is marked, until the appeal is concluded, 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 Ayo-Adesanya's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Malik. He submitted that an interim suspension order for a period of 18 months is necessary to protect the public and is otherwise in the public interest.

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 its decision to impose a striking-off order as the only appropriate and proportionate sanction in the circumstances. For the same reasons set out in its decision for the substantive order, the panel has decided to impose an interim suspension order.

The panel determined that an 18-month period is required to allow sufficient time for any appeal lodged to conclude.

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

That concludes this determination.