Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 26 February 2024 – Friday, 1 March 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Olayinka O Sule Oluwaleye**	
NMC PIN	06I0240E	
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH: Mental health nurse, level 1 (7 December 2006)	
Relevant Location:	London	
Type of case:	Misconduct	
Panel members:	Michelle McBreeze Donna Green Clara Cheetham	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Andrew Granville-Stafford	
Hearings Coordinator:	Anya Sharma (26 February 2024) Dilay Bekteshi (27 February 2024 – 1 March 2024)	
Nursing and Midwifery Council:	Represented by Simeon Wallis (26 – 29 February 2024, 1 March 2024), Case Presenter Represented by Robert Rye (1 March 2024), Case Presenter	
Ms Oluwaleye:	Present and represented by Adewuyi Oyegoke	
Facts proved by admission:	All	
Facts not proved:	N/A	
Fitness to practise:	Currently impaired	
Sanction:	Suspension order (6 months)	

Interim order: Interim suspension order (18 months)

On day 1 of the hearing, the panel were provided with the Agreed Statement of Facts, which states:

2. *"It is agreed that the facts underlying the above charges are as follows:*

Patient A

a. *Patient A was a patient at Chelsea and Westminster Hospital (the Hospital). He was elderly and suffered with Parkinson's disease which, among other things, meant he was unsteady and at risk of falls.*

b. *At the relevant time, Patient A was experiencing delirium, which was believed to be a result of an underlying infection. He would often try to leave the ward. As a result of his attempts to leave, a Deprivation of Liberty Safeguard (DOLs) was in place. Nonetheless, his care plan made clear that 'manual restraint should be avoided, if possible… restraint may annoy [Patient A] and increase his frustration' and therefore 'if it is ever restraint necessary, use only for the shortest possible time'. Patient A also had pneumonia and was taking antibiotics for that.*

c. *On 19 May 2019, Patient A was made subject of 2-1 care at night and required 'constant observation'. Patient A's care plan defines constant observation as 'within eyesight at all times and in close proximity… within arm's length when he is walking around and within 2 metres at the most when he is on his bed but awake'.*

d. *This level of observation (2.1, constant observation) was the required level of observation at the time relevant to the charges.*

Patient A's grandson

e. *Patient A's grandson is a paramedic. Due to the nature of his work, he was permitted to visit his grandfather outside of normal visiting hours.*

The Registrant

f. *The Registrant was not a regular member of ward staff. On 08-09 June 2019, she, and another nurse (Colleague A), had been employed from the staff bank to provide 2-1 care to Patient A.*

08/09 June 2019

g. *On 09 June 2019 at c. 03.00am, Patient A's grandson attended the Hospital. As he had done many times before, he decided to pop in to see his grandfather.*

h. *When he arrived at Patient A's door, he found it to be locked. He knocked several times over c. 2 minutes. No one came to the door.*

i. *The evidence is unclear whether, having knocked for a few minutes Patient A's grandson went to the nurses' station to inform one of the nurses, [Ms 1], that the door was locked or whether his knocking alerted her but, in any event, [Ms 1] became aware that the door was locked and also began knocking. By this point, she was calling the Registrant and Colleague A's name through the door.*

j. *Patient A's grandson's evidence is that he and [Ms 1] knocked on the door for a further c. 2 minutes. [Ms 1] evidence is that she believes she was knocking for 4-6 minutes.*

k. *The Parties agree that, on any reading, Patient A's grandson and [Ms 1] were knocking on the door for a substantial period of time before it was opened by Colleague A.*

l. *Both Patient A's grandson and [Ms 1], formed the impression from Colleague A and the Registrant's appearance that they had been sleeping.*

m. *The Registrant admits that they were right to come to that conclusion and that the door had been locked to prevent their sleeping on duty being discovered.*

n. Colleague A initially refused to allow Patient A's grandson and [Ms 1] to enter and shut the door again but more knocking induced her to allow them in.

o. Upon entry, it was clear that the room had been arranged to allow the Registrant and Colleague A to sleep. The room was dark with the main lights off and a blanket over a small lamp. The armchairs were covered with blankets and pillows.

p. By contrast, Patient A had no blankets, his pyjama top was unbuttoned and pulled to one side, his legs were exposed, and his head was almost leaning to the right bedrail. His bed was tilted at a 45 degree angle with his legs higher than his head. He was sleeping, with a pool of phlegm covering the right side of his face. Upper airway secretions could be heard as he breathed. Patient A's grandson considers he was 'hypoxic and blue' and that his mouth was full of vomit and sputum.

q. It was perfectly obvious from the state Patient A was found in, and is now admitted by the Registrant, that he had not been kept under adequate observation, that the position he had been placed in was unsafe and intended to prevent him getting out of bed and that he was at risk of aspirating or death as a result.

r. As to risk, Patient A was not able to expectorate and swallow his secretions and therefore needed to be upright at all times, even when sleeping, due to the risk of aspirating.

s. Having discovered Patient A as indicated above, [Ms 1] suctioned him to remove the secretions and cleaned him.

t. Patient A's grandson asked for Registrant's name, but she did not provide it. Instead, she 'did not say a single thing throughout the incident'.

u. *The Registrant accepts that, in the circumstances, it was reasonable for Patient A's grandson to ask for her name and that in failing to give it she acted without integrity."*

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Wallis, on behalf of the Nursing and Midwifery Council (NMC), to amend the schedule of charge by way of inserting six additional charges in relation to dishonesty.

Mr Wallis submitted that this is a case that deals with a relatively serious incident. He submitted that in the aftermath of that incident, on three occasions you gave different accounts of what had happened on the evening of 8/9 June 2019. Mr Wallis referred the panel to an extract from Patient A's handwritten clinical notes dated 9 June 2019, as well as an email that you had sent on 11 June 2019 which provides an account of what had happened on the night shift of 8 June 2019. He further referred the panel to the minutes of your investigation meeting dated 4 July 2019.

Mr Wallis submitted that although no charges were originally laid as a result of these three accounts, this application to amend the charge is made on the basis that the charges that are already before the panel are understood to be admitted.

Mr Wallis informed the panel that it is also understood that there is an agreed statement of fact, which sets out the agreed facts in relation to charges one to five and includes material which is already before the panel. It also sets out broad admissions of dishonesty in relation to these facts.

Mr Wallis submitted that the underlying fact of dishonesty may very well be admitted by you, and that if that is the case, then there is very little prejudice or injustice with it being specified in the charges.

Mr Wallis submitted that if the amendment is refused and there is a dispute, the panel will effectively still have to consider the substance of that issue at the impairment stage.

Mr Oyegoke submitted that he opposes the application to amend the charges. He referred the panel to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules):

Amendment of the charge

28. (1) At any stage before making its findings of fact, in accordance with [rule 24(5) or (11)] 145, the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) [or the Fitness to Practise]146 Committee, may amend

(a) the charge set out in the notice of hearing; or

(b) the facts set out in the charge, on which the allegation is based,

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

Mr Oyegoke submitted that this incident took place more than four years ago, and that you have taken time to prepare your case based the schedule of charges you were provided with by the NMC. He submitted that it would be unfair to you, on the morning of the first day of the substantive hearing, where you have made admissions and have signed an agreed statement of fact, that the NMC now make an application to amend the charges.

Mr Oyegoke submitted that looking at the merit of the case and fairness of the proceeding, this amendment can only be made with injustice to you. He submitted that the panel are aware of the significance and the implications of the dishonesty charges on you, and on that basis he opposes the application.

The NMC propose to amend the charges to add the following additional charges in addition to those already before the panel:

6. That you recorded incorrectly in Patient A's notes on 9 June 2019:

a. that the door had been locked in order to prevent him from disturbing other patients after midnight;
b. that his safety had been maintained all night;
c. that he had brought up phlegm shortly before his grandson arrived to visit and you had been about to attend to him.

7. That you said incorrectly in your email of 11 June 2019 that:
a. That the door had been locked from 1.30am to prevent patient A from getting into other patient's bays;
b. That you were going to get your gloves on to clean Patient A's mouth at the time his grandson arrived.

8. That you said incorrectly at the investigation meeting on 4 July 2019 that
a. You locked the door at around 1:30am so that Patient A could not get out;
b. That Patient A's head was raised up at about 45 degrees;
c. That you were going to get your gloves on to clean Patient A's mouth at the time his grandson arrived.

9. Your actions at 6a, 7a, and 8a, were dishonest in that you knew that the door had been locked to prevent your sleeping on duty being discovered.

10. Your actions at 6b and 8b were dishonest in that you knew that Patient A had been placed at an unsafe angle and inadequately supervised.

11 Your actions at 6c, 7b and 8c were dishonest in that you knew you had not taken steps to clean Patient A's mouth at the time his grandson arrived.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. It bore in mind that in the agreed statement of facts there are references to your conduct being accepted as dishonest. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. The panel considered that if the additional charges were not added there would be a risk of undercharging in respect of this incident. The panel further considered that it was fair to allow the amendments on the grounds of public protection. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

The amended schedule of charge now reads as follows:

That you, a registered nurse:

1. *On 08-09 June 2019, when responsible for providing 2 to 1 care to Patient A:*

    a. *Placed Patient A in bed and/or allowed Patient A to be placed in bed at a 45 degree angle, when to do so was unsafe.*
    b. *Arranged Patient A's room and/or allowed Colleague A to arrange Patient A's room so as to allow you and her to sleep whilst on duty.*
    c. *Failed to keep Patient A under any/any adequate observation.*
    d. *Slept whilst on duty and/or allowed Colleague A to do so.*
    e. *Locked the door to Patient A's room and/or allowed the door to Patient A's room to be locked by Colleague A.*
    f. *Did not provide your name to Patient A's grandson when asked to do so.*

2. *Your actions at 1a were intended to prevent Patient A getting out of bed and disturbing your and/or Colleague A's sleep.*

3. *Your actions at charges 1a and/or b and/or c and/or d knowingly placed Patient A at risk of aspiration and/or death.*
4. *Your actions at charge 1e were intended to prevent your sleeping whilst on duty*
   being discovered.
5. *Your actions at charge 1f lacked integrity in that you should have complied with*
   Patient A's grandson's request, which was reasonable in the circumstances.

6. *That you recorded incorrectly in Patient A's notes on 9 June 2019:*
   a. *that the door had been locked in order to prevent him from disturbing other patients after midnight;*
   b. *that his safety had been maintained all night;*
   c. *that he had brought up phlegm shortly before his grandson arrived to visit and you had been about to attend to him.*

7. *That you said incorrectly in your email of 11 June 2019 that:*
   a. *That the door had been locked from 1.30am to prevent patient A from getting into other patient's bays;*
   b. *That you were going to get your gloves on to clean Patient A's mouth at the time his grandson arrived.*

8. *That you said incorrectly at the investigation meeting on 4 July 2019 that*
   a. *You locked the door at around 1:30am so that Patient A could not get out;*
   b. *That Patient A's head was raised up at about 45 degrees;*
   c. *That you were going to get your gloves on to clean Patient A's mouth at the time his grandson arrived.*

9. *Your actions at 6a, 7a, and 8a, were dishonest in that you knew that the door had been locked to prevent your sleeping on duty being discovered.*

10. *Your actions at 6b and 8b were dishonest in that you knew that Patient A had been placed at an unsafe angle and inadequately supervised.*

11. *Your actions at 6c, 7b and 8c were dishonest in that you knew you had not taken steps to clean Patient A's mouth at the time his grandson arrived.*

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

Mr Wallis opened the case in line with the agreed statement of facts.

Decision and reasons on facts

You admitted all the charges on the following basis:

That you, a registered nurse:

1. *On 08-09 June 2019, when responsible for providing 2 to 1 care to Patient A:*

    a. *Placed Patient A in bed ~~and/~~or allowed Patient A to be placed in bed at a 45 degree angle, when to do so was unsafe.*
    b. *Arranged Patient A's room ~~and/~~or allowed Colleague A to arrange Patient A's room so as to allow you and her to sleep whilst on duty.*
    c. *Failed to keep Patient A under ~~any~~/any adequate observation.*
    d. *Slept whilst on duty ~~and/~~or allowed Colleague A to do so.*
    e. *Locked the door to Patient A's room ~~and~~/or allowed the door to Patient A's room to be locked by Colleague A.*
    f. *Did not provide your name to Patient A's grandson when asked to do so.*

2. *Your actions at 1a were intended to prevent Patient A getting out of bed and disturbing your ~~and~~/or Colleague A's sleep.*
3. *Your actions at charges 1a and~~/or~~ b and/~~or~~ c and/~~or~~ d knowingly placed Patient A at risk of aspiration ~~and/~~or death.*
4. *Your actions at charge 1e were intended to prevent your sleeping whilst on duty*

being discovered.

5. *Your actions at charge 1f lacked integrity in that you should have complied with*
   Patient A's grandson's request, which was reasonable in the circumstances.

6. *That you recorded incorrectly in Patient A's notes on 9 June 2019:*
   a. *that the door had been locked in order to prevent him from disturbing other patients after midnight;*
   b. *that his safety had been maintained all night;*
   c. *that he had brought up phlegm shortly before his grandson arrived to visit and you had been about to attend to him.*

7. *That you said incorrectly in your email of 11 June 2019 that:*
   a. *That the door had been locked from 1.30am to prevent patient A from getting into other patient's bays;*
   b. *That you were going to get your gloves on to clean Patient A's mouth at the time his grandson arrived.*

8. *That you said incorrectly at the investigation meeting on 4 July 2019 that*
   a. *You locked the door at around 1:30am so that Patient A could not get out;*
   b. *That Patient A's head was raised up at about 45 degrees;*
   c. *That you were going to get your gloves on to clean Patient A's mouth at the time his grandson arrived.*

9. *Your actions at 6a, 7a, and 8a, were dishonest in that you knew that the door had been locked to prevent your sleeping on duty being discovered.*

10. *Your actions at 6b and 8b were dishonest in that you knew that Patient A had been placed at an unsafe angle and inadequately supervised.*

11. *Your actions at 6c, 7b and 8c were dishonest in that you knew you had not taken steps to clean Patient A's mouth at the time his grandson arrived.*

Mr Wallis informed the panel that the NMC accepted these admissions. The panel therefore announced these facts proved by way of your admissions.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

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

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

In terms of seriousness, Mr Wallis directed the panel's attention to the relevant guidance. He submitted that the gravity of this situation lies in the fact that you were entrusted to oversee Patient A, a vulnerable elderly gentleman who was acutely unwell. You were entrusted to provide assistance during an overnight shift where his safety was under your responsibility, yet you deliberately increased the risk. He submitted that this is a significant concern for individuals who must entrust their loved ones to the care of professionals. The professionalism of a nurse should serve as a comforting reassurance to family members in such circumstances.

Mr Wallis submitted that this behaviour does not stem from a lack of clinical skills or understanding of the required care. He pointed out that dishonesty issues are especially critical in this situation, given that Patient A's well-being was compromised. He further submitted that although rectifying your actions may be challenging, it is not impossible. He submitted that the panel would require compelling evidence of your recognition of the issues at hand and your efforts towards remediating the concerns.

Mr Oyegoke submitted that not all breaches of the Code automatically result in misconduct. Regarding misconduct, he emphasised the need for the panel to assess each charge individually. He submitted that when considering impairment, the panel should evaluate both your current practices and your overall professional career. He highlighted the significance of examining how you have taken steps to address and improve your practice. Nevertheless, he directed the panel's attention to references from your employer and testimonials that commend your character. He noted the ongoing investigation since 2019 and highlighted your continuous work post-incident. Mr Oyegoke made reference to your present employer's immediate awareness of the situation, with your manager appreciating your honesty and transparency.

Mr Oyegoke invited the panel to give due consideration to these factors when assessing your current impairment. He also mentioned your completion of specific training, including your recent duty of candour certificate, and public references showcasing positive opinions of you despite the 2019 events. He argued that it would be in the public interest to allow a proficient nurse to return to practice.

Mr Oyegoke referred the panel to the case of *PSA v NMC* [2017] CSIH 29 and *Uppal* [2015] EWHC 1304 (Admin). He submitted that they are relevant in this case and asked the panel to take these into account in its considerations of misconduct and impairment.

Your evidence on oath

In response to Mr Oyegoke's questions, you stated that you became a registered mental nurse in 2006 and provided an overview of your work history from that year. You detailed your employment at Central Northwest London from 2007 to 2015, where you worked as a registered nurse in a psychiatric intensive care unit. Subsequently, in 2015, you also assumed a bank specialist nurse role at the hospital while maintaining your position at Central Northwest London. Your employment at Chelsea and Westminster was terminated when allegations surfaced.

From 2019 onwards, you said you took care of your children at home until September 2019 when you began working at Cygnet. In your current role, you care for vulnerable individuals, including those at risk of suicide or lacking capacity, in the psychiatric intensive care unit.

When asked about encountering patients similar to Patient A, you mentioned dealing with confused patients whom you observed. You highlighted that there have been no prior or subsequent allegations similar to those faced in 2019.

You said that your manager at Cygnet submitted a reference in 2020 acknowledging their awareness of the NMC proceedings against you. You said you promptly

disclosed the situation to your manager, expressed remorse for your actions, and followed their advice to engage in self-improvement.

During the hearing, you expressed regret for the incident on 9 June 2019, emphasising that you have learnt from the experience and prioritised patient care since.

Addressing Mr Wallis' questions, you accepted responsibility for your actions on 9 June 2019, you affirmed your dedication to patient care while acknowledging the failure to meet nursing standards on that day in question.

Since September 2019, you said you resumed work at Cygnet following a childcare break and returned refreshed in January 2022. You said that even though the prior allegations did not result in regulatory action, you proactively disclosed them to your employer when the incident re-emerged.

When questioned about accepting culpability for the conduct in question, you clarified that you acknowledged your mistakes both in the internal investigation and during this hearing. Despite initial denials of certain allegations, you now accept all charges and take full responsibility, committing to preventing similar occurrences in the future.

Application under Rule 31

Following Mr Wallis' questioning of you, he made an application under Rule 31 to admit a reflective piece submitted by you to the NMC during an interim order hearing in October 2023. He submitted that the document is relevant, stating that it sheds light on your perspective up to late 2023.

Mr Wallis highlighted three areas of relevance: firstly, the document's value in assessing the progression of your insight, whether at its earliest stages or developing; secondly, its impact on weighing the credibility of testimonials and your disclosures to the authors regarding the charges admitted (excluding dishonesty

charges); and finally, its role in evaluating your oral evidence credibility and transparency regarding your prior admissions to others.

In discussing the document's content, Mr Wallis emphasised its importance, noting that it includes a narrative of the events on that night in question. The description provided differs from your admissions to the charges in that it indicates that the door was locked solely for Patient A's safety and to prevent their exit from the room. Similarly, it also portrays you cleaning the patient upon Ms 1's entry, with no mention of sleeping on duty. Mr Wallis submitted that the document reflects a sense of denial which contrasts with your admissions to the charges. Mr Wallis submitted that your account has evolved, displaying variance rather than outright contradiction, warranting the panel's awareness of this progression. Consequently, he invited the panel to consider the document's contents.

Mr Oyegoke opposed the application. He submitted that the document in question, a reflective piece, was initially intended for the NMC and had been presented during an interim order hearing in October 2023. He outlined several reasons why introducing this document would be detrimental to your case. Emphasising the panel's independence, he highlighted that the charges were not formulated at the time the document was prepared, and the aspect of dishonesty had not been deliberated upon. Mr Oyegoke noted the unconventional progression of the case, originally starting with no case to answer. Presenting the document now, he submitted, would be prejudicial to you, especially considering that the panel could assess your current impairment independently. He also emphasised the evolving nature of the case, with significant charges having been recently presented to you. In light of these developments, he submitted that allowing the admission of this document would be unfair and would not have any probative value.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel reached a decision based on the submissions at hand, refraining from reading the document. Acknowledging that the reflective piece was submitted during an interim order hearing where charges had not yet been formally laid out, it is presumed that you possessed some level of awareness regarding the concerns leading to the present allegations.

The panel has determined the fairness and relevance of the document based on its origins as a submission made by you to the interim order hearing panel in 2023. Notably, the panel considered its relevance to the current case. It determined that the document holds relevance to your current oral evidence, particularly concerning insight and remediation. In light of its significance to the proceedings, the panel decided that it is fair and relevant to admit the reflective piece at this stage.

Your oral evidence continued

Following the panel's ruling on the Rule 31 application, Mr Wallis further questioned you about the reflective piece submitted during the October 2023 interim order hearing. You explained that your reflections were rooted in your emotions at the time, devoid of any specific guidance. You said your reflection was not directed by any yes or no questions, it was more about your feelings and how you could better yourself for patients in your care.

Regarding your decision to sleep on duty, you clarified that while it was not explicitly mentioned in the 2023 reflective piece as you had not been specifically asked about this. However, you said you had reflected on it. Acknowledging an omission in your previous account, you admitted that locking the door was actually to conceal the fact that you had been sleeping during the shift, not merely to prevent the patient from leaving the room. Despite this, you maintained a stance of acknowledging your past mistakes.

When questioned by the panel about interactions with Patient A's family, you recalled apologising to them in 2019, but later acknowledged that this apology did not occur. Regarding maintaining Patient A observations whilst you were asleep, you did not provide an explanation but acknowledged your shortcomings.

In terms of patient care, you explained actions taken to address Patient A's coughing, citing the use of nearby tissues. You admitted fault in not seeking assistance promptly. You also detailed disclosing NMC proceedings to your employer upon receiving the referral, explaining the situation chronologically.

When asked about your mindset in relation to your decision-making during those incidents, you highlighted your intent to care for Patient A without intentions of neglect. When questioned about Patient A's well-being and your assertion in your reflective piece that no harm had come to Patient A, you said that no harm came to the patient due to your regular observations which indicated his stability.

In response to further queries about self-improvement measures, you outlined completing various courses independently to enhance your skills, including mental health awareness and safeguarding courses. You emphasised ongoing self-evaluation and feedback-seeking to progress effectively.

Regarding your current work status, you said you are working part-time as a mental health nurse, adjusting your schedule due to childcare responsibilities.

Following the panel’s questions. Mr Wallis raised concern about the discrepancies between your evidence and your admissions in relation to charges 1e), 4), 6c) and 11). However, in re-examination by Mr Wallis, you reconfirmed the accuracy of the pleas and that the admissions were properly made.

Closing submissions on misconduct and impairment

In closing submissions, Mr Wallis submitted that your conduct in this case can be characterised as a breach of fundamental tenets of the nursing profession. He submitted it is reflective of an attitude of disregard both for the safety of the patient and the importance of honesty and accountability beyond any technical deficiency in the understanding of the duty of candour.

Mr Wallis invited the panel to consider the NMC guidance “*Has the concern been addressed?”* (Reference FTP-13b). He submitted that the insight demonstrated by

you in your reflective piece and your evidence before the panel is well short of what is sufficient to remediate the concerns in this case. He noted that the reflective piece and your evidence acknowledge in general terms the nature of the concerns in this case and the seriousness of what took place and refer to some reflection that you have undertaken. You apologised in general terms for your conduct and gave assurance that it will not be repeated. However, he submitted that those apologies often were in answer to questions about your motivations, which, if answered directly, might have demonstrated considerably greater insight.

Mr Wallis submitted that your evidence also tended to give the impression that you had been forthcoming and apologetic about your wrongdoing from the outset. He submitted that is only partially accurate. He said that until formulation of specific charges, you advanced an account which denied specific and significant parts of the conduct that you now admit, and maintained parts of your earlier account which you now accept were dishonest. Mr Wallis submitted that it is right that you are entitled to reserve your position or advance a defence as you choose at the various stages of fitness to practise proceedings and ought not to be penalised for doing so. However, he submitted that it would not be right for the panel to then accept unchallenged evidence from you positively asserting that you had always accepted every part of your wrongdoing.

Mr Wallis referred the panel to the NMC guidance which deals with the significance to be afforded to references and testimonials. He submitted that your testimonials make clear that you had told the authors about a regulatory concern in 2022, but it was unclear whether they were aware of the full extent of what was alleged or that it would be accepted by you. Mr Wallis submitted that your suggestion that the authors had been aware of your poor conduct since 2019 or 2022 should be seen in light of the evidence that you denied significant part of that until recently.

Mr Wallis submitted that public protection is engaged in this case as well as public confidence in the profession would be undermined if a finding of impairment were not made. He submitted that an informed member of the public who was aware of the charges found proved would be seriously concerned by the misconduct in this care, which strikes at the heart of the trust the public place in professionals.

In closing submissions, Mr Oyegoke referenced relevant cases and emphasised the enduring impact of the proceedings on one's career. He highlighted that individuals who had provided you with the references were fully aware of the allegations faced and pointed out instances of demonstrated honesty and integrity.

Mr Oyegoke stressed the significance of the references and emphasised their positive portrayal of you as an honest, hardworking, and dependable professional. He argued that there is no evidence suggesting a risk of recurrence or complaints about your conduct and urged the panel to give due weight to the compelling references, noting that your current employer expresses no concerns and is impressed by your performance.

Furthermore, Mr Oyegoke submitted that you have shown remorse and a substantial level of insight. He commended your accountability and the seriousness with which you have approached the proceedings. He pointed out that you have actively engaged in training, including mandatory and requested courses like the duty of candour training. Highlighting your reflective practices and the absence of repeated incidents over the past five years, he submitted that the risk of recurrence is low.

Mr Oyegoke invited the panel to find that your fitness to practise is not currently impaired, emphasising the importance of reinstating a competent nurse.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor.

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

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

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

2.6 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

4 Act in the best interests of people at all times

10 Keep clear and accurate records relevant to your practice
10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

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

Charges 1a), 1b), 1c), 1d), 2) and 3)

The panel noted the multiple concerning behaviours in your treatment of Patient A. Neglecting Patient A's care, falling asleep on duty, failing to observe him adequately, intentionally restraining the patient from leaving the bed, and knowingly exposing him to risks of harm such as aspiration or death are considered very serious. The panel determined that your actions directly contradicted the fundamental principles of nursing and professional conduct. It noted that neglecting patient care and deliberately sleeping on duty not only jeopardised the patient's well-being but also erode the trust expected in nurses to deliver continuous and attentive care. It also noted that inadequate observation compromises patient safety and intentionally restricting a patient's movement violates their rights, while knowingly subjecting them to risks like aspiration or death shows a callous disregard for patient safety and well-being.

The panel therefore found that your actions in the aforementioned charges placed Patient A at a serious risk of harm. It also took into account evidence indicating harm, such as the patient being cold, blue in the face and hypoxic. Patient A's heightened vulnerability due to the Deprivation of Liberty Safeguards being in place and other health complications made the situation even more precarious. As a result, the panel determined that your actions fell significantly short of the expected conduct and standards of a nurse and constitutes serious misconduct.

Charge 1e), 1f), 4), 5)

The panel noted that you prioritised your personal needs over patient care and attempted to conceal those actions, placed Patient A in a perilous situation. Such behaviour is not only shocking but also a clear deviation from the expected

standards of nursing conduct. The panel noted that it was understandably distressing for Patient A's grandson to witness the state of Patient A and request the names of the responsible nurses. The panel deemed this request justifiable given the circumstances. Based on these findings, the panel concluded that your actions constituted to serious misconduct.

Charges 6), 7), 8), 9), 10) and 11)

The panel noted that in charges 6 - 11, you falsified patient documentation and resorted to dishonesty on two further occasions to deny and in order to cover up your actions. This dishonest behaviour was directly related to your work and involved deceiving your employer. The panel unequivocally deemed this conduct as extremely serious, as it falls significantly below the expected standards expected of a nurse and compromise the trust and integrity essential in the nursing profession. The panel therefore determined that your actions in the above charges constitutes misconduct.

The panel therefore found that all the charges, individually and collectively, amount to serious misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

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

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

The panel considered that limbs a), b), c) and d) of Dame Janet Smith's test as set out in the Fifth Shipman Report were engaged by your past actions. The panel found that your conduct put Patient A at serious risk of physical and emotional harm. The

panel also considered that members of the public would not expect a registered nurse to behave in such a manner. The panel therefore considered that your actions brought the profession into disrepute and also breached fundamental tenets of the profession. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel had regard to the test set out in the case of *Cohen*. It determined that the nature of your dishonesty, persisting over an extended period, presents challenges in terms of showing insight and remediation. The panel also highlighted concerning attitudinal issues apparent in the lack of compassion towards Patient A.

In examining whether you have taken steps to strengthen your practice, the panel considered the evidence at hand, including your oral evidence, reflective piece, testimonials, and certificates. It also had regard to the NMC guidance on *'Insight and Strengthened Practice'* (Reference FTP-14).

During your oral evidence, you said that no concerns were raised about your practice both prior to and following the incidents. You also expressed remorse for your actions. However, the panel observed that your responses lacked depth when prompted about your motivations, with frequent apologies in place of direct answers. The absence of a coherent explanation for behaving the way you did during this serious incident signalled a lack of insight on your part. While recognising your efforts in providing training certificates, references and testimonials, the panel concluded that your level of insight is still developing. The panel therefore could not be assured that the risk of repetition is low in this case and determined that a finding of impairment is necessary on the grounds of public protection.

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

public would expect from registered nurses responsible for providing safe and effective care to patients. The panel determined that a finding of impairment was also necessary on public interest grounds, in order to maintain public confidence in the nursing profession and in the NMC as a regulator, and to declare and uphold proper standards of conduct and performance.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

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

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

Submissions on sanction

The panel received written submissions from Mr Wallis. He further submitted that the panel should consider the full range of available sanctions and find a fair balance between the nurse, midwife or nursing associate's right and the objectives of public protection and maintaining confidence in the profession. He submitted that the NMC suggests in this case that a striking off order is necessary to maintain public confidence in the profession and for the protection of the public. He referred the panel to the NMC Guidance '*The available sanctions'* (Reference SAN-3b) and the relevant case law.

Mr Wallis outlined the aggravating factors. He submitted that this is a case which is suggestive of deep-seated personality problems in relation to both attitude to the safety of patients, and to honesty. Insight into the reasons misconduct of this sort occurred is essential to any real possibility of remediation. He said that you have

asserted that you have insight, are remorseful and would not repeat your misconduct. Mr Wallis said that this may be demonstrative of some insight into the seriousness of concerns but still falls far short of the ‘compelling evidence’ of insight necessary to remediate the serious concerns raised by this case.

Mr Wallis submitted that in respect of proportionality, it is acknowledged that the consequences of a striking-off order will usually be severe for a registrant. However, in this case that is outweighed by the ‘essential issue’ to protect the public from the still-present risk of repetition.

The panel considered Mr Oyegoke's submissions. He submitted that the panel should consider the entirety of its decision including the facts, misconduct, and impairment stages. He invited the panel to also focus on your remediation and suggested the least restrictive sanction be imposed. Even though the panel has determined current impairment, Mr Oyegoke submitted that this does not automatically warrant a severe sanction. He proposed no further action may be taken and that the fitness to practise process itself could serve as a cautionary example to the public against such behaviour.

Furthermore, Mr Oyegoke acknowledged the gravity of the situation, citing the dishonesty, potential harm and vulnerability of Patient A. However, he also pointed out several mitigating factors, such as the incident occurring five years ago, your unblemished 18-year career, and your immediate approach to your present employer upon learning of the NMC proceedings. He highlighted this as an isolated scenario in an otherwise commendable career, emphasising your acknowledgment of your wrongdoing.

Mr Oyegoke suggested that a caution order would sufficiently mark the seriousness of the conduct. He also recommended a conditions of practice order, noting that your insight is evolving and can continue to improve through practice. Given your successful practice before and after the incident, he deemed a conditions of practice order as workable and proportionate. He submitted that a suspension or striking-off order would be excessive and counterproductive to your growth and remediation. Ultimately, Mr Oyegoke submitted that the public interest would be served by

allowing a competent and otherwise dedicated nurse like yourself to continue in the nursing profession.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Deliberately placed a vulnerable person, Patient A, at serious risk of harm.
- Deliberately failed to fulfil the duty of care towards Patient A, by prioritising your own needs above that of a vulnerable patient.
- Engaged in an extended period of dishonest conduct.
- Lack of meaningful insight into your misconduct.

The panel also took into account the following mitigating features:

- Expressed remorse and has taken some steps to address the identified concerns.
- No prior or subsequent issues or complaints.
- Positive testimonials from your present employer and numerous character references.

The panel then assessed the nature of the dishonesty in this case. The panel took into account the NMC guidance *'Cases involving dishonesty'* (Reference SAN-2), which states:

"Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *incidents outside professional practice"*

The panel highlighted the significant concerns in this case, including deliberate breaches of the professional duty of candour, harm to a vulnerable patient, direct risks to a patient in your care, and premeditated deception. Whilst your actions formed part of one overall incident, there were multiple instances of dishonesty. As a result, the panel determined that the level of dishonesty in this case fell at the higher end of the spectrum of seriousness.

The panel went on to consider what sanction, if any, it should impose in this case.

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, which states that this sanction may be appropriate where some or all of the following factors are apparent:

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

The panel determined that, due to the nature of the charges found proved, no workable conditions could be formulated in this case. The misconduct identified extends beyond the scope of simple retraining as it is primarily linked to your attitudinal issues. It noted that the lack of insight cannot be remedied solely through

training but requires a more detailed explanation on the circumstances and decision-making leading to your behaviour on 8/9 June 2019 and the incident's impact on the patient, their family, and colleagues. Given the seriousness of the case, involving lack of compassion and neglect of Patient A, and a protracted period of dishonesty, the panel found it challenging to devise practical conditions to address these concerns. Furthermore, the panel concluded that imposing conditions of practice would not sufficiently address the gravity of the panel’s findings or sufficiently serve the public interest.

The panel then went on to consider whether to impose a suspension order. The panel took into account the SG which states that this sanction may be appropriate when some or all of the following factors are apparent:

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

The panel had regard to the NMC guidance on *“Serious concerns which are more difficult to put right”* (Reference FTP-3a).

Whilst, as previously determined, the panel considered that the charges in this case formed part of one overall incident, there were multiple instances of dishonesty and therefore it could not be said that this case concerned a single instance of misconduct. It also considered the underlying attitudinal issues. The panel noted that although the incident occurred on the evening of 8/9 June 2019 out of many worked over your nursing career, when looking at the overall context, the panel found that the lack of compassion and care for a significantly vulnerable patient, in conjunction with concealing your actions and being dishonest, were serious departures from what would be expected of a nurse. The panel's utmost priority is to ensure the

public is suitably protected and was of the view that you should address the outstanding concerns before being allowed back into the nursing profession.

However, the panel has borne in mind the length of time you have worked since the incident, your remorse, positive testimonials and steps to remediate your misconduct. It has found that you have some insight, albeit at a developing stage.

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

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct and the public interest. This timeframe also allows you an opportunity to fully reflect on your misconduct, take action and provide evidence of your commitment to address your failures.

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

Any future panel reviewing this case would be assisted by:

- Any relevant up to date testimonials and/or feedback from employer(s).
- A reflective piece:
    - Explaining what led you to your decision-making with regard to your misconduct on the night in question.
    - reflecting on what you have learned from these past experiences and how you have changed your practice.
    - reflecting on the impact of your conduct on the patient, his relative, colleagues and the reputation of the profession.
    - what you have learned from any recent training addressing the concerns raised by the findings and how that training has influenced your approach to future practice.

Interim order

As the suspension order cannot take effect until the end of the twenty eight day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Rye. He submitted that an interim suspension order should be imposed for a period of eighteen months to cover the twenty eight day appeal period and the subsequent period should an appeal be lodged. He submitted that this is necessary for the same reasons as given by the panel regarding the substantive order.

Mr Oyegoke opposed the application as you have continued to work for five years without any concerns. He submitted that there is a high bar for an interim order in

cases like this and that threshold has not been crossed as you have worked without any concerns.

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

Decision and reasons on interim order

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

The panel concluded that the only proportionate interim order would be that of an interim suspension order, as to do otherwise would be inconsistent with its earlier findings.

Should you decide to lodge an appeal, given the uncertainty in relation to how long any appeal may take to conclude, the panel decided that this interim suspension order shall be for a period of eighteen months.

Therefore, the panel determined to impose an eighteen-month interim suspension order on your registration.

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

That concludes this determination.

This will be confirmed to you in writing.