Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

Monday, 7 April 2025 - Friday, 11 April 2025 (Physical)

Monday, 14 April 2025 (Physical)

Wednesday, 1 October 2025 - Friday, 3 October 2025 (Virtual)

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

Name of Registrant:	**Christian Ifeanyi Agwuncha**
NMC PIN:	19H0045E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing (Level 1) – 20 September 2019
Relevant Location:	London Borough of Newham
Type of case:	Misconduct
Panel members:	Carolyn Tetlow (Chair, Lay member) Sarah Morgan (Registrant member) Robert Fish (Lay member)
Legal Assessor:	Angus Macpherson
Hearings Coordinator:	Sabrina Khan
Nursing and Midwifery Council:	Represented by Stephanie Stevens, case presenter (7 -11 April 2025, 14 April 2025) Giedrius Kabasinskas, case presenter (1 - 3 October 2025)
Mr Agwuncha:	Present and represented by Dr Abbey Akinoshun
Facts proved:	1a), 1b), 1c), 1d), 1e), 2a), 2b), 3a), 3b) and 4
Facts not proved:	N/A

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

Details of charges

That you, a registered nurse:

1) On 2 November 2020, in relation to Patient A:

    a) Saw Colleague A punch Patient A and did not act appropriately;
    b) Did not check Patient A for injuries;
    c) Did not put safeguarding measures in place for Patient A;
    d) Did not escalate and/or report that Colleague A punched Patient A to a senior member of staff;
    e) Did not report that Colleague A punched Patient A to safeguarding.

2) On 2 November 2020, in relation to Colleague A:

    a) Did not support/address the physical altercation with Patient A with Colleague A;
    b) Allowed Colleague A to continue working on the same ward with vulnerable patients including Patient A.

3) On 2 November 2020, did not:

    a) Document that Colleague A punched Patient A;
    b) Document that Patient A was injured;

4) Breached the duty of candour in that your actions/omissions in Charge 3 were deliberate to conceal that Patient A had been punched by Colleague A and subsequently injured in order to downplay the role staff and you had in leading to the patient's seclusion.

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

Decision and reasons on application to amend the charges

The panel heard an application made by Ms Stevens, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charge 4. The proposed amendment was to amend charge 4 as follows:

- To include an allegation of dishonesty and / or breach of a duty of candour in respect of charges 1d and/or 1e and
- To allege dishonesty (in addition to a breach of a duty of candour) in respect of charges 3a and/or 3b.

It was submitted by Ms Stevens that the proposed amendment would provide clarity and more accurately reflect the evidence. The charge as amended would read:

4) *"**Were dishonest and/or** breached the duty of candour in that your actions/omissions in **charge(s) 1d and/or 1e and/or 3a and/or 3b** were deliberate to conceal that Patient A had been punched by Colleague A and subsequently injured in order to downplay the role staff and you had in leading to the patient's seclusion."*

Ms Stevens referred the panel to the case of *PSA v NMC & Jozi* [2015] EWHC 764; where the court observed that a panel proceeding without the full gravity of allegations being presented may fundamentally misunderstand the case. As the court observed, *'the four charges that should have been brought in this case were never brought, and the case went off on a fundamentally misconceived footing'.*

Ms Stevens also referred the panel to the case of *Regulation of Health Care Professionals v General Medical Council and Ruscillo*, [2004] EWCA Civ 1356;

where the Court of Appeal affirmed that fitness to practise tribunals must play a proactive role greater than that of a judge in a criminal trial in ensuring that relevant evidence and issues are properly presented. It is the duty of the panel to ensure that the full seriousness of the case is before it.

Ms Stevens submitted that the facts underpinning this application have not changed. However, she submitted that the NMC's assessment regarding this case has, and that it is necessary, in the interests of fairness, clarity, and public protection, to allege dishonesty as a distinct and standalone allegation.

Ms Stevens submitted that focusing solely on breach of the duty of candour risks narrowing the panel's perspective and could inadvertently downplay the gravity of the alleged conduct. She submitted that dishonesty is qualitatively different from mere breach of candour, and its inclusion ensures that the panel can properly assess the nature and seriousness of the regulatory concerns.

Ms Stevens acknowledged the panel will have concerns that allowing the proposed amendment notified to you so shortly before the hearing, may appear unfair. However, she submitted that by clearly distinguishing dishonesty from breach of candour, you will have an opportunity to respond precisely to what is alleged.

Ms Stevens submitted that under the current framing, you may be placed in the difficult position of defending a charge that implicitly suggests dishonesty without being able to address it directly. She submitted that introducing a standalone dishonesty charge will afford you the latitude of pleading to the breach of candour allegations without admitting dishonesty. She submitted that this distinction will also assist the panel in its deliberations.

Ms Stevens submitted that dishonesty has been a consistent theme in this case. She explained that in February 2024, the Case Examiners notified you that the case should proceed in respect of the regulatory concerns of dishonesty and/or lack of candour. She informed the panel that the dishonesty element was removed in August 2024 by the case progression team. She told the panel that recent developments, including a supplementary statement received from Witness 1 last

week, have led the NMC to reconsider this position. Additionally, she submitted that your consistent denials and lack of engagement with the breach of candour charges made it necessary to explicitly present the full nature of the regulatory concern.

Ms Stevens submitted that you were notified of the proposed amendment on Thursday, 4 April 2025. She submitted that the NMC initially considered that charging dishonesty might be seen as excessive; however, further review and evidence made clear that not doing so risks undercharging and undermining public confidence in the process.

Ms Stevens submitted that based on the facts presented before the panel, it is necessary to present the full regulatory concern. She therefore invited the panel to exercise its discretion under Rule 28 and allow the amendment to include dishonesty in the charges.

Dr Akinoshun, on your behalf, submitted that this matter was referred to the NMC in 2022 and since that time, the case has progressed through the ordinary case management stages, including disclosure of allegations, your response and consideration by the Case Examiners.

Dr Akinoshun submitted that dishonesty was not charged in August 2024; the focus of the proceedings thereafter was limited to matters concerning the duty of candour. He submitted that it is of critical importance to note that you were not put on notice that dishonesty would feature in this case following that date. He submitted that the application to amend the charges was only made at the commencement of this substantive hearing, which is almost three years after the original referral and without prior notice to you. Dr Akinoshun informed the panel that you were first made aware of the proposed amendment last Thursday, 4 April 2025, with only Friday and the weekend available to consider the issue before today's hearing.

Dr Akinoshun referred to the case of *R v Secretary of State for the Home Department, ex parte Doody* [1993] UKHL 8, [1994] 1 AC 531; where the House

of Lords confirmed that fairness demands that individuals be afforded adequate notice of the case they are required to meet. He said this principle is central to natural justice and procedural fairness.

Dr Akinoshun submitted that the timing of the proposed amendment is procedurally unfair. He submitted that you have not been afforded a reasonable opportunity to consider or respond to this serious new allegation. He submitted that being notified only days before the substantive hearing does not constitute sufficient notice in accordance with legal and procedural standards. Dr Akinoshun submitted that the NMC has had conduct of this case since 2022. If dishonesty was genuinely a concern, it should have been identified and incorporated into the original or final charges well before now. He submitted that to raise it at this late stage undermines the integrity of the process and creates a real and substantial risk of injustice.

Dr Akinoshun submitted that you have prepared for this hearing based on the charges as framed up to the notification received last Thursday. He submitted that to allow the amendment now would significantly prejudice your ability to present a full and effective defence. He added that dishonesty is not a minor or technical amendment; it constitutes a qualitatively different and significantly more serious allegation that requires a distinct evidential and legal approach. He further submitted that this is not a mere relabelling of existing conduct but the introduction of a wholly new allegation after a substantial delay.

Therefore, Dr Akinoshun invited the panel to refuse the NMC's application to amend the charges.

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 carefully considered the submissions made by Ms Stevens and Dr Akinoshun.

The panel was of the view that it was in the interests of justice to allow the proposed amendment to charge 4 as it better reflected the evidence before it and the seriousness of the concerns being considered.

The panel accepted that the nature of the allegation, namely a deliberate attempt to conceal material facts relating to the treatment of Patient A, may properly engage issues of dishonesty, and that framing the charge accordingly is appropriate in the regulatory context.

The panel noted that the duty of candour set out at paragraph 14 in the NMC Code does not refer to dishonesty. The panel was therefore of the view that charge 4 as previously drafted did not clearly encompass an allegation of dishonesty (although it is reflected in a footnote to the Code). The panel was mindful of the fact that the NMC as a regulatory body is under a duty to specifically allege dishonesty if that is its intention. Charge 4 as originally formulated does not do that.

Nevertheless, the panel accepted Ms Stevens' submission that presenting the charge in its amended form serves the public interest and ensures that the full gravity of the regulatory concern is clearly pleaded and can be properly considered.

The panel recognised that the proposed amendments would extend the allegation of dishonesty and breach of the duty of candour to charges 1d and/or 1e.

The panel was not convinced by Ms Stevens' reasons as to why this application to amend was notified to you and your representative, just one working day before the first day of the scheduled hearing. The panel noted that you had responded to the allegations when they were formulated as regulatory concerns. The denials which you made were in July 2023. Although there was some new evidence, most, if not all of the evidence had already been available to the NMC. The panel considered that, if the hearing proceeded immediately, the amendment would cause procedural unfairness to you. There has been insufficient time for your representative to hold a case conference, to review the evidence in the light of the amended charge and prepare a response to it. It concluded that you should have

sufficient time to consider the amended charges and to consult with your representative.

However, the panel considered that such unfairness could be satisfactorily addressed by providing you and Dr Akinoshun additional time to prepare.

Accordingly, the panel directed that the hearing resume at 12:00 pm on 8 April 2025, thereby providing you and Dr Akinoshun two half days to review the amended charge, consider the exhibits and convene the case conference that was not possible due to unavailability on the previous Friday.

This approach seeks to balance the need for fairness to you with the public interest in ensuring that the proceedings address the full scope of the regulatory concerns.

Details of charges, as amended

That you, a registered nurse:

1) On 2 November 2020, in relation to Patient A:

    a) Saw Colleague A punch Patient A and did not act appropriately;
    b) Did not check Patient A for injuries;
    c) Did not put safeguarding measures in place for Patient A;
    d) Did not escalate and/or report that Colleague A punched Patient A to a senior member of staff;
    e) Did not report that Colleague A punched Patient A to safeguarding.

2) On 2 November 2020, in relation to Colleague A:

    a) Did not support/address the physical altercation with Patient A with Colleague A;

b) Allowed Colleague A to continue working on the same ward with vulnerable patients including Patient A.

3) On 2 November 2020, did not:

a) Document that Colleague A punched Patient A;
b) Document that Patient A was injured;

4) Were dishonest and/or breached the duty of candour in that your actions/omissions in charge(s) 1d and/or 1e and/or 3a and/or 3b were deliberate to conceal that Patient A had been punched by Colleague A and subsequently injured in order to downplay the role staff and you had in leading to the patient's seclusion.

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

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

At the outset of the hearing, Ms Stevens made a request that this case be held partly in private on the basis that proper exploration of your case involves viewing CCTV footage which includes images of patients and other members of staff. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Dr Akinoshun indicated that he supported the application to the extent that the viewing of any CCTV footage should be conducted in private.

Furthermore, Dr Akinoshun made a request that this case be held partly in private on the basis that proper exploration of your case will involve reference to [PRIVATE].

Ms Stevens indicated that she supported the application to the extent that any reference to [PRIVATE] should be heard in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session when CCTV footage is viewed and [PRIVATE] are made, in order to protect the privacy and confidentiality of patients and staff who appear in the CCTV footage, and your privacy and confidentiality.

Background

You were referred to the NMC on 8 February 2022, from East London NHS Foundation Trust ("the Trust"). It is alleged that on 2 November 2020, you witnessed a colleague assault a patient but did not take remedial action to safeguard the patient. It is also alleged that you did not document the assault or the resulting injury in order to conceal that the assault had happened.

Decision and reasons on application for an adjournment to seek further evidence

During Witness 1's cross-examination, Dr Akinoshun made an application to adjourn the hearing in order to allow Witness 1 time to research your sickness records, in order to better understand the chronology of events. Furthermore, he submitted that this information may be relevant to the credibility of Witness 1. You dispute Witness 1's evidence that you took a long period of time off sick, stating that you were only off sick one day.

Ms Stevens opposed the application. She submitted that this line of enquiry is unclear. She submitted that the panel is currently seized with determining whether the facts of charges 1c, 1e, 3b, and 4, those which are not admitted, are proved. She further submitted that the question of whether or not you were on sick leave during certain periods will not materially assist the panel in resolving the core issues underpinning those charges. Therefore, she submitted that this line of enquiry appears to be peripheral at best.

Ms Stevens submitted that there is already a body of evidence before the panel that supports the account given by Witness 1 in his witness statement and oral testimony. She submitted that his evidence has been tested and substantiated through both documentation and corroborating witness accounts. She said that the suggestion that the absence of sickness records undermines Witness 1's credibility is speculative, and she submitted that an adjournment to seek those records would be disproportionate in the context of the wider evidential matrix.

Moreover, Ms Stevens submitted that Dr Akinoshun has had in his possession the materials, including the relevant emails and witness statements, for several months. She submitted that, at no point prior to this stage of the proceedings, was a request made to investigate or verify your sickness absence records despite you having had ample opportunity to raise this matter at an earlier stage. She submitted that no sufficient explanation has been provided by Dr Akinoshun as to why this information is being pursued now, at a point when doing so will jeopardise progress and may well compromise the chances of the hearing being completed within the scheduled time.

Further, Ms Stevens submitted that even if the sickness records were to be obtained, it remained unclear what material impact they would have. Witness 1 was not your line manager, nor was he responsible for administering or recording sick leave. Therefore, she submitted that Witness 1's awareness, or lack thereof, of specific periods of absence does not directly speak to the factual allegations under consideration. As such, she submitted that the weight that could be attached to such evidence is likely to be minimal.

Finally, Ms Stevens submitted that the stated purpose of this evidence, to challenge Witness 1's credibility, must be balanced against the panel's duty to conduct proceedings fairly, efficiently, and proportionately. In this instance, she submitted that the potential evidential value of the requested material is significantly outweighed by the delay and disruption an adjournment would cause, particularly when the issue does not go to the heart of the matters the panel must determine.

Therefore, Ms Stevens invited the panel not to grant the adjournment.

The panel considered the application for a short adjournment to allow Witness 1 time to research your sickness records. In making its decision, the panel accepted the advice of the legal assessor and noted the submissions made by Dr Akinoshun and Ms Stevens.

Having fully considered the matter, the panel decided not to allow the application for an adjournment. The panel's reasons are as follows:

- Unclear extent of dispute: The panel was not entirely clear on the precise extent of the dispute between the parties with respect to the sickness records. The issue appears to be tangential rather than central to the matters it was required to determine.

- Limitations of the Witness's role: Witness 1 was not your line manager and did not have responsibility for managing or arranging sickness absence. The panel is not therefore satisfied that he is in a position to provide authoritative evidence on the sickness records in question.

- Passage of time: The events under discussion occurred approximately four and a half years ago. This lapse in time may reasonably affect the availability of any evidence that might now be obtained, particularly where the witness was not directly involved in the matter.

- Impact on credibility, not central facts: The panel noted that the issue of sickness records has been raised in order to challenge Witness 1's credibility. However, the matter does not go to the core facts that the panel must determine in this hearing.

- Proportionality and efficiency: Adjourning the hearing to obtain this additional evidence would risk compromising the panel's ability to conclude the hearing within its scheduled timeframe. In light of the limited relevance and potential utility of the evidence, the panel considered that granting the adjournment would be disproportionate.

Accordingly, the application for an adjournment was refused.

Decision and reasons on application to admit additional emails

During your evidence in chief, Dr Akinoshun made an application to adduce additional emails concerning your requests to review the CCTV footage, as evidence to support his submission regarding the credibility of Witness 1, who had stated that you had not requested sight of the CCTV footage.

Ms Stevens submitted that she was unclear about the relevance of these emails to the core facts of the case and the charges.

The panel accepted the advice of the legal assessor.

The panel determined that given that the emails in question were readily available and may conceivably assist your case, the panel decided to admit the additional emails as evidence.

Decision and reasons on application to adduce further documentation

During the course of your cross-examination, it came to the attention of Ms Stevens that the documentation contained in the NMC bundle and relied upon in relation, in particular, to charges 3b and 4, may be incomplete. The Datix forms completed by you and Colleague A appear in the bundle as screenshots of a single page document. You gave evidence that the Datix forms ran to a number of pages and included a box for any injuries to be detailed, which were not included on the single page versions before the panel.

Ms Stevens submitted the NMC had not been made aware of the point which you made until your oral evidence. She submitted that this may be directly relevant to the allegations and may also speak to your credibility and honesty and that of Witness 1.

In light of this, Ms Stevens submitted that it would be fair and appropriate to try to obtain this documentation, should it exist. Therefore, on 10 April 2025 she made an application for the full Datix forms to be sought.

Dr Akinoshun supported this application. He submitted that the documentation sought may contain information supporting your account and may help your case.

The panel accepted the advice of the legal assessor.

The panel carefully considered the application made by Ms Stevens to obtain further documentation. It accepted that the documentation in question is relevant to charges 3b and 4 in as much as it may disclose that you documented the injury sustained by Patient A. It is apparent that this part of the form has not yet been provided and may contain information critical to assessing the events in question.

The panel considered that obtaining this documentation is in the interests of fairness to both parties. If, as indicated by you, the form does indeed contain information supporting your account, it would be in your interest for it to be adduced. Conversely, if the documentation does not support your position, it may assist the NMC in proving elements of charges 3b and 4.

In either scenario, the panel is satisfied that the documentation is potentially probative and directly relevant to the charges before it.

Accordingly, the panel granted the application and directed that reasonable steps be taken by the NMC to obtain the documentation from the Trust as soon as possible.

The panel was subsequently informed that the Datix forms had been archived and were unlikely to be available. It therefore decided to recall Witness 1 and he gave further evidence under affirmation about whether the injury had been documented.

Decision and reasons in respect of the admissibility of the documentation

However, the Datix forms were in fact obtained by the NMC on 11 April 2025. On reading them, Dr Akinoshun opposed their admission, explaining that, you having perused them, it was your case that they were not in fact exactly as they had been completed by you. He made submissions and relied upon the following:

- On page 3 of your Datix form, the box enquiring whether the incident required use of restraints, de-escalation techniques, segregation or seclusion was not completed when it would have been, as restraints were used and Patient A was secluded;
- On page 3 of the Datix form, the box asking whether anyone was injured, was not completed, whereas you had told him that it was completed;
- There were many boxes on the form which bore asterisks which were not completed. He stated that unless such boxes were completed, it was not possible to submit the form.

Dr Akinoshun submitted that the two forms, apparently completed by you and by Colleague A had been doctored and were not as you had completed them.

Ms Stevens submitted that according to the evidence provided by you yesterday, you had mentioned that the Datix form cannot be changed once it is submitted but now you are saying that it had been doctored. She submitted that it is very unclear at present as to which version stated by you is correct.

The panel accepted the advice of the legal assessor.

The panel read the Datix forms. It took into account Dr Akinoshun's objections and determined that they did not justify refusing their admission. The absence of a completed box relating to restraint etc. did not strike the panel as being of particular relevance given that you had completed boxes elsewhere on the form relating to restraint. The reliance upon the injury box not being completed assumes that you did complete it, when that was the point in issue. It determined to allow you to give evidence about this. The panel considered that the documentation may be directly

relevant to charge 3b and your credibility along with the credibility of Witness 1. The panel determined that it is fair to admit the documents because both parties had agreed to admit the documents the day before, but that you would have the opportunity to give evidence about the authenticity of the forms.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Dr Akinoshun who informed it that you made full admissions to charges 1a, 1b, 1d, 2a, 2b, 3a.

The panel therefore found charges 1a, 1b, 1d, 2a, 2b, 3a proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Stevens on behalf of the NMC and by Dr Akinoshun on your behalf.

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

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

- Witness 1: Matron in the Forensics directorate of East London NHS Foundation Trust (ELFT);

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1c

"That you, a registered nurse:

1) On 2 November 2020, in relation to Patient A:

c) Did not put safeguarding measures in place for Patient A;"

This charge is found proved.

In reaching this decision, the panel took into account both the oral and documentary evidence including Exhibit GC/01, Exhibit GC/04, the safeguarding policy, CCTV footage, Exhibit GC/03 and the oral evidence of Witness 1.

Ms Stevens submitted that in charge 1a you have admitted seeing Patient A being punched by Colleague A. However, she submitted that despite this you stated in your interviews dated 16 April and 21 June 2021 that you did not believe a safeguarding incident had occurred and characterised the actions as self-defence. Nevertheless, she submitted that the CCTV footage clearly shows a physical altercation, which Witness 1 described as a safeguarding incident.

Ms Stevens submitted that you accepted in your evidence that, when a patient suffers physical harm, safeguarding measures must be taken. She submitted that the safeguarding policy and oral evidence require the following actions:

a) Completion of a safeguarding form – She submitted that this was not done.
b) Escalation to the Duty Senior Nurse (DSN) or on-call manager – She submitted that this was not done. You admitted this in both oral evidence and in charge 1d.

c) Informing a medic of the physical altercation – again this was not done. She relied upon the documentation from the trainee doctor who attended Patient A at 23:31 on 2 November 2020 and who completed the relevant form stating: '*No concerns regarding injury or physical health'.*
d) The Datix form you completed should have noted safeguarding concerns and steps taken – it did not.

Ms Stevens submitted that your failure to follow safeguarding procedures, despite acknowledging harm to the patient, is clear. She submitted that in your own statement on 2 November 2020 (Exhibit GC/04) you recognise that you should have escalated the matter.

In contrast Dr Akinoshun submitted that there were already safeguarding measures in place for Patient A. He submitted that the care plan would provide sufficient clarity for staff regarding Patient A's management. He submitted that Witness 1 accepted under cross-examination that no previous or similar concerns had ever been raised about your practice.

Dr Akinoshun submitted that, if there had been a genuine safeguarding concern, one would reasonably expect the Trust to have either suspended you or promptly referred you to the NMC. Instead, he submitted, that the referral was made nearly two years later, which calls into question the motivation for the referral and raises concerns that the NMC process was being used punitively in response to your resignation.

The panel noted that you admitted to witnessing the assault on Patient A, charge 1a. The panel noted that the Trust's safeguarding policy, which was produced in evidence, applied to all staff, and provides that every registrant has a duty of care to respond to incidents involving actual or potential harm.

The panel did not accept your evidence that sufficient and appropriate safeguarding measures were already in place via the patient's care plan and that they represented a sufficient or appropriate regime which could deal with a new safeguarding event, namely the physical assault of a patient. It appeared to the panel that you did not

have a proper understanding of the safeguarding policy or your role, since you did not undertake any safeguarding measures after the incident. The panel accepted Witness 1's evidence that*:*

"It is everyone's responsibility to keep someone safe."

The panel noted your later reflections during cross-examination and in response to questions from the panel on what you would do differently. These included an acknowledgement that you would now take steps such as escalating to the Duty Senior Nurse, sending Colleague A home, informing the medic, and ensuring clear documentation.

The panel concluded that you ought to have taken immediate safeguarding measures following the assault. Your failure to do so was contrary to policy and guidance. Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 1e

"That you, a registered nurse:

1) On 2 November 2020, in relation to Patient A:

e) Did not report that Colleague A punched Patient A to safeguarding."

This charge is found proved.

In reaching this decision, the panel considered arguments made regarding the authenticity of the Datix form.

You told the panel that the version of the Datix form provided was not the same as the one you originally submitted. You alleged that certain mandatory fields marked with asterisks had not been completed, and therefore, the form could not have been

submitted in that state. You also told the panel that you believe Witness 1 has doctored the Datix form.

The panel noted:

- The Datix form in question bore the same reference number and reporter details as the version in the bundle;
- You confirmed during cross-examination that it was submitted under your own login, which is why you are listed as the reporter;
- There were 22 fields containing asterisks which had no entries. On your account the form could not have been submitted with these fields blank. The entries must therefore have been deliberately removed either after the form was submitted or prior to its admission into evidence. The panel did not find this explanation credible;
- The form had been migrated from its original Datix system into the Trust's InPhase system;
- There was no evidence to suggest tampering by the Trust or Witness 1;
- Two separate internal Trust investigations concluded that the Datix form did not include mention of the assault or injury.

Accordingly, the panel found the Datix form to be genuine and accurate. This finding had a bearing on Charges 1e, 3b and 4.

Ms Stevens relied on the evidence submitted in relation to charge 1c and additionally on the Witness Statement of Witness 1.

Ms Stevens submitted that despite witnessing the incident, you did not raise a safeguarding alert. You sought to justify this by saying you were not the Duty Senior Nurse. However, she submitted that the safeguarding policy is clear: '*any nurse who suspects harm must act'*.
Ms Stevens referred the panel to your own regulatory concerns response form dated 21 February 2022, where you acknowledged that an alert should be raised if harm is suspected. Yet you did not do so. She submitted that instead you relied on the Datix

report, which you claimed was sufficient, even though, as you admitted, this would go to management, not safeguarding.

Dr Akinoshun submitted that you did not report Colleague A's actions to safeguarding at the time because you did not fully comprehend what had happened due to the speed of the incident. He submitted that your delay was due to incomplete understanding. You had sought to remedy this by requesting to view the CCTV footage, in order to understand the incident, but had been prevented from seeing it.

The panel determined that your position was that you had completed the Datix report and therefore fulfilled your duty to inform the management, thereby discharging yourself from reporting the incident to safeguarding. However, the panel found that the Datix form:

- Did not mention any safeguarding concerns;
- Did not record that the patient was injured;
- Indicated "*No*" to the question: *"Does this incident have safeguarding adult implications?".*

Although it may not have been your responsibility to report the incident to safeguarding, it was your responsibility to report the incident to your manager, or another senior member of staff accurately and comprehensively and in such a way as to reflect what had actually happened in order to escalate the matter. The panel concluded that even if you believed someone else would make a safeguarding report, you had a duty to ensure the relevant information was before that person in order that it should be done appropriately. Your failure to complete the Datix and the seclusion authorisation accurately and appropriately meant that a report to safeguarding could not be made. As a matter of fact, you did not make a report to safeguarding yourself.

Therefore, on the balance of probabilities, the panel found this charge proved.

Charge 3b

"That you, a registered nurse:

3) On 2 November 2020, did not:

b) Document that Patient A was injured;"

This charge is found proved.

In reaching this decision, the panel took account of the documentary evidence, the additional Datix form and the submissions made by Ms Stevens and Dr Akinoshun.

Ms Stevens noted that you admitted that you saw a bruise on Patient A's face, that allegedly being the reason why you called the trainee doctor. However, the trainee doctor recorded no injuries. This indicates she was not informed of the bruising. She submitted that Witness 1 also confirmed that no proper documentation of the injury existed.

Ms Stevens submitted that it is clear from the Datix report that you completed that you did not record the injury and that the injury was never documented by you at all.

Dr Akinoshun submitted that you denied this allegation and directed the panel to a statement you had given to the Trust, which purported to be dated 2 November 2020 (Exhibit GC/04), in which you recorded a bruise on the left cheek of Patient A. He submitted that the complete Datix form which the NMC adduced in evidence had been doctored by Witness 1. He submitted that the actual Datix form that you had completed had documented the injury (bruises on his cheek).

Dr Akinoshun also submitted that you had informed the trainee doctor about the injury and that was the reason why she had come to assess the patient.

The panel determined that the Datix form completed by you, which it had found to be accurate and not *'doctored*', did not disclose the injury to Patient A. The injury was not known to the duty doctor who was simply called to review the patient in seclusion at 11:30, and therefore only conducted a *'panel inspection',* rather than going into the room to check on the patient. It took account of the fact that the injury was noted the

following day by another member of clinical staff and was visible as swelling and a black eye. The injury was not mentioned in the Datix form completed by you or in the seclusion authorisation completed by you.

The panel acknowledged that in your signed statement dated 2 November 2020, you claimed to have recorded the injury on the Datix form. However, there was no evidence of this record. Further, both internal investigations of the Trust concluded that no documentation of the injury was made by you. One of these investigations was completed by Witness 1 and another person, but a preliminary investigation carried out by a third person had reached the same conclusion.

Given the available evidence and inconsistencies in your position, the panel found that you had failed to document the injury. Therefore, this charge is proved.

Charge 4

"That you, a registered nurse:

4) *Were dishonest and/or breached the duty of candour in that your actions/omissions in charge(s) 1d and/or 1e and/or 3a and/or 3b were deliberate to conceal that Patient A had been punched by Colleague A and subsequently injured in order to downplay the role staff and you had in leading to the patient's seclusion."*

This charge is found proved.

In reaching its decision, the panel considered the totality of the evidence presented, including oral testimony, contemporaneous documentation, and your own written and oral accounts. The panel also applied the legal test for dishonesty as set out in *Ivey v Genting Casinos* [2017] UKSC 67.

Ms Stevens submitted that your actions and omissions in charges 1d, 1e, 3a and 3b were deliberate and intended to conceal that Patient A had been punched and subsequently injured, in order to downplay the role of staff, including yourself, in leading to the patient's seclusion. She referred the panel to a timeline of contradictory statements from you including:

- Denials on 3 November 2020;
- Admission after being informed of CCTV;
- Further denials and changes in accounts from December 2020 through to 2023 including your responses to the NMC;
- An admission during this hearing that you had seen the punch and the injury.

Ms Stevens submitted that this pattern of shifting accounts demonstrates a clear failure to act openly and honestly.

Ms Stevens referred the panel to the NMC Duty of Candour (DMA-8), which states that registrants are expected to:

- Be honest and truthful;
- Escalate concerns without delay;
- Fully disclose harm to patients;
- Cooperate with investigations.

She submitted that none of these duties were fulfilled. She submitted that you had repeatedly denied witnessing the assault, only conceding the truth when faced with irrefutable evidence in the form of CCTV footage. She submitted that your lack of immediate disclosure, failure to document the incident accurately, and evasion of accountability amounted to a breach of duty of candour.

Ms Stevens submitted that during this hearing you admitted knowledge of the assault, yet you consistently attempted to deflect or obscure the truth. She concluded that your conduct was dishonest and that you were in breach of your professional duties.

Dr Akinoshun submitted that this charge is denied. He submitted that you did not witness the alleged assault. He submitted that you did not take any action because you had not clearly seen the punch. This would have been otherwise had you seen it. He reiterated that had you seen the assault, you knew the appropriate safeguarding steps and would have taken them without hesitation.

Dr Akinoshun submitted that your failure to take further steps was not a deliberate omission but an unfortunate error in judgment under extremely challenging circumstances.

Dr Akinoshun submitted that your actions were not an attempt to conceal or mislead. He submitted that you were not involved in the alleged physical contact, nor did you have any motive to shield Colleague A. He submitted that you were not friends with Colleague A or known to each other outside of work. He further submitted that there was no professional or personal benefit for you to protect Colleague A at the expense of your own registration and career.

Dr Akinoshun submitted that given your experience and familiarity with the environment including knowledge of CCTV coverage and previous involvement in footage reviews, it would be illogical for you to deliberately misrepresent facts knowing that the footage would ultimately be reviewed.

Dr Akinoshun submitted that Witness 1's evidence was undermined by inconsistencies and a lack of corroboration, rendering it unreliable and insufficient as a basis for adverse findings. He gave three examples of matters which he claimed demonstrated Witness 1's lack of credibility.

Dr Akinoshun referred the panel to the witness statement of Witness 1 where Witness 1 claimed that you refused to participate in the Trust's investigation. However, he submitted that the evidence before this panel confirms otherwise. He submitted that you engaged with management on at least three occasions and remained cooperative throughout the investigation process, contrary to the assertion made by Witness 1.

Secondly, Dr Akinoshun submitted that Witness 1 claimed that you had been off sick for an extended period and had threatened not to return to work. However, you have confirmed that you had been off sick for only one day prior to resigning on 7 October 2021.

Thirdly, Dr Akinoshun submitted that Witness 1 had given inaccurate evidence under affirmation, asserting that you had not requested to see the CCTV footage. He

submitted that this was clearly contradicted by documentary evidence, as there was email correspondence which shows that you had made repeated requests to view the footage.

The panel determined that you knew that Patient A had been punched by Colleague A and that Patient A had sustained a visible injury. It noted that you had initially acknowledged this in a written statement dated 2 November 2020, in which you described witnessing the incident. Further you admitted charge 1a which reads:

That you, a registered nurse:

1) On 2 November 2020, in relation to Patient A

a) *Saw Colleague A punch Patient A and did not act appropriately*

However, during oral testimony before the panel, you sought to deny this admission, suggesting the event was too quick and unclear to fully comprehend.

Notwithstanding your admission to charge 1a, the panel carefully considered your evidence in relation to whether you had seen the punch. It considered whether you had in fact retracted that admission during the course of your evidence. It reached the conclusion that it should not accept your evidence as a retraction of your admission. Having viewed the CCTV footage, the panel found it inconceivable that you, who were in such close proximity to the incident and looking directly at it, did not clearly witness the punch. The footage depicted a violent event that would have registered with any reasonable and attentive staff member. Moreover, all staff, including you, are seen to move toward the patient instinctively, indicating their awareness of what had just occurred.

The panel concluded that your evidence was inconsistent in numerous respects and that your actions and omissions were designed to conceal the incident in that:

- You failed to document the punch or the resulting injury in the Datix form or the seclusion documentation;
- You claimed to have verbally handed over the incident to a senior colleague, but you were unable to recall what you said during that handover;
- Your assertion that you mentioned the incident to a senior colleague was not

reflected in the reports which you filed. This suggests that you failed to escalate the incident;

- You inconsistently asserted that you had both informed a doctor and recorded the injury, yet contemporaneous medical and incident records contradict these claims;
- You arranged for a junior colleague to submit a nearly identical second Datix form. According to Witness 1, this was highly unusual and in itself indicative of a coordinated attempt to frame the event so as to blame the patient.

The panel noted that the language used in the Datix form appeared purposefully constructed to portray the patient as the aggressor and to justify the use of seclusion. It noted that the report failed to mention the colleague's violent conduct and instead focused exclusively on the patient's behaviour. The panel found this to be an intentional reframing of events to shift blame onto the patient, thereby concealing the staff member's misconduct.

The panel was particularly concerned that this concealment may have directly contributed to inappropriate clinical decisions:

- The next shift, relying on your report, responded by changing the patient's treatment, including changing their medication and determined to involve the police in authorising the use of a taser.
- When the incident came to light the next day through the patient's complaint, appropriate steps were taken, including safeguarding referrals, a police report, and CQC notification, none of which had been triggered by your actions.

In assessing dishonesty, the panel applied the *Ivey* test. In applying the Ivey test, the panel determined your knowledge and belief: you knew that Colleague A had punched Patient A and you were aware that Patient A had been injured.

Notwithstanding your knowledge and belief, you did not take the actions set out in paragraphs 1c, 1e and 3a and 3b of the charge.

The panel considered your explanations for not doing so as follows:

- You were relatively inexperienced in the role;

- You were stressed and confused during a busy night shift;
- You misunderstood your safeguarding obligations in such an eventuality.

However, the panel found these explanations inadequate. It determined that you were clearly aware of the significance of the event, as you described it as a novel and dramatic incident and knew that you were required to report it. The panel determined that your shifting explanations, inconsistencies in your evidence, and your selective reporting render these alternative explanations most unlikely.

The panel considered each of the submissions made by Dr Akinoshun to undermine the credibility of Witness 1. However, the panel determined that the inconsistencies, such as they were, can be explained by a failure of memory due to the passage of time and the fact that Witness 1 was not your line manager. It concluded that there was no evidence to suggest that Witness 1 had any animosity against you. It found Witness 1's evidence to be credible and reliable.

The panel was satisfied that ordinary decent people, in the light of that knowledge and belief, would consider it dishonest not to escalate and / or report that Colleague A punched Patient A to a senior nurse and not report that Colleague A had punched Patient A to safeguarding. Further it considered that ordinary decent people, in the light of that knowledge and belief, would consider it dishonest not to document that Colleague A had punched Patient A and not to document that Patient A was injured. By your inaction as set out in charges 1d, 1e, 3a and 3b, you failed completely to disclose the nature of the incident and its consequences which were known to you, and thereby failed to safeguard the patient and report a dangerous occurrence of which you were aware.

The wording of the charge obliges the panel to consider whether you acted deliberately and whether the motive was, as the NMC allege:

> *'in order to downplay the role staff and you had in leading to the patient's seclusion.'*

The panel found that motive proved. You were aware that Colleague A had assaulted Patient A, and that Patient A was injured. You were aware that that was a

serious matter which ought to be documented and reported to senior staff and safeguarding. You knew that not doing so as the only nurse present would mean that the incident would not be properly recorded, and the participants not identified. Had the patient not reported it, the assault may never have come to light.

The panel found that you deliberately concealed that Patient A had been punched and injured, and did so dishonestly, within the meaning of the *Ivey* test. Further it finds that thereby you breached the duty of candour.

Accordingly, on the balance of probabilities charge 4 is proved in its entirety.

Interim Order

Upon the panel handing down its determination on facts, Ms Stevens indicated that she wished to make an application for an interim suspension order for 12 months. There was insufficient time for such an application to be heard. The chair informed you that the NMC intended to make such an application and indicated to you that it is likely to be listed in the near future.

The hearing adjourned part-heard at this stage and resumed on 1 October 2025. The NMC was represented by Mr Kabasinskas at the resumed hearing.

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 ability to practise kindly, safely and professionally.

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.

The panel received two additional documents at this stage:

- Your reflective piece
- A bundle of four training certificates and two references

Submissions on misconduct

Mr Kabasinskas submitted that the process before the panel requires two stages: first, whether the facts found proved amount to misconduct; second and only if they do, the panel should go on to consider whether, in light of that misconduct, your fitness to practise is currently impaired.

Mr Kabasinskas reminded the panel that there is no burden or standard of proof at this stage, misconduct and impairment are matters of judgement for the panel.

Mr Kabasinskas submitted that in the case of *Roylance v General Medical Council (No 2)* [2000] 1 A.C. 311, misconduct was defined as '*a word of general effect involving some act or omission which falls short of what would be proper in the circumstances.*' He added that in the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), misconduct was said to require a serious falling short of expected standards, conduct which fellow professionals would regard as deplorable. He further added that in *Holder v NMC* [2017] EWHC 1565 (Admin), the High Court confirmed that the key issue is the seriousness of the conduct, judged by reference to the principles in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kabasinskas submitted that proper standards are to be assessed with reference to the NMC Code, which you were bound by at all material times. He applied the Code to each of the proven charges and made the following submissions.

Charge 1 – Failure to act following assault on Patient A

Mr Kabasinskas submitted that you failed to check Patient A for injury, failed to safeguard or escalate, and failed to report the colleague who had assaulted him.

This breached numerous sections of the Code, including 1.1, 1.2, 1.4, 1.5, 2.6, 3.3, 3.4, 13.1, 13.2, 13.4, 16.1,17.1,17.3, 19.1 and 19.4.

He submitted that these breaches exposed a vulnerable patient to harm, and amount to misconduct.

Charge 2 – Failure to manage colleague after assault

Mr Kabasinskas submitted that you allowed the colleague who had punched Patient A to continue working with vulnerable patients, without addressing the incident.

This breached sections 8.2, 8.4, 8.5, 8.6, 8.7 and 9.1 of the Code.

He submitted that not addressing the physical altercation and allowing an unsafe colleague to continue, placed patients at risk and constituted misconduct.

Charge 3 – Failure to document incident

Mr Kabasinskas submitted that you failed to record the incident, or its consequences, in the patient's notes.

This breached sections 10.1, 10.2, 10.3, 14.3 and 17.2 of the Code.
He submitted that accurate documentation is central to safe practice and the deliberate failure to document such a significant event fell far below expected standards, amounting to misconduct.

Charge 4 – Breach of duty of candour / dishonesty

Mr Kabasinskas submitted that you failed to act with candour, concealed that Patient A had been punched, and downplayed staff involvement in the incident.

This breached sections 14.1, 14.2, 20.1 and 20.5 of the Code.

He referred the panel to the NMC guidance on dishonesty, submitted that honesty is a fundamental tenet of the nursing profession and reminded the panel that dishonesty is regarded as a most serious concern by the NMC, particularly where it undermines patient safety. He therefore submitted that charge 4 also amounts to misconduct.

In summary, Mr Kabasinskas submitted that across all four charges your conduct represented a serious departure from the standards expected of a nurse. He submitted that the conduct fell significantly short of what was required, breached multiple provisions of the Code, and therefore amounted to serious professional misconduct.

Dr Akinoshun submitted that the panel is aware of the two-stage process. He submitted that the panel must first determine whether the facts found proved amount to misconduct. He submitted that only if misconduct is established does the panel move on to consider whether, as a result, your fitness to practise is currently impaired.

Dr Akinoshun submitted that in this case, certain charges namely 1a, 1b, 1d, 2a, 2b), and 3a were admitted and found proved; the remainder were found proved by the panel.

Dr Akinoshun submitted that a finding of fact alone does not automatically lead to impairment. Each stage requires separate consideration, as emphasised in *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Dr Akinoshun accepted on your behalf that the facts proved may properly amount to misconduct. However, Dr Akinoshun submitted that the panel must also bear in mind the following:

- The incident was isolated in an otherwise unblemished career.
- You are of impeccable character, which the NMC has not disputed.
- There is no attitudinal concern. This was not a pattern of behaviour but a single lapse.

Accordingly, while Dr Akinoshun accepted that the proved facts do constitute misconduct, they must be assessed in the broader context at the impairment stage.

Submissions on impairment

Mr Kabasinskas 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 *Grant.*

Mr Kabasinskas submitted that the critical question for the panel is whether you can now practise safely, kindly and professionally. He referred the panel to the decision of Mrs Justice Cox in *PSA v NMC and Grant*, and referred to Dame Janet Smith's *"test",* tailored to this case, asking whether you have:

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

c) *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) *in the past acted dishonestly and/or is liable to act dishonestly in the future*

Applying the test to this case, Mr Kabasinskas made the following submissions:

Limb A – Risk of harm: Mr Kabasinskas submitted that Patient A suffered both physical and emotional harm as a result of your failure to act. He submitted that other patients were also placed at risk.

Limb B – Disrepute: Mr Kabasinskas submitted that the conduct was sufficiently serious to bring the profession into disrepute.

Limb C – Breach of fundamental tenets: Mr Kabasinskas submitted that you breached fundamental tenets, in particular the duty to safeguard and advocate for vulnerable patients. Honesty is also a fundamental tenet of the nursing profession.

Limb D – Dishonesty: Mr Kabasinskas submitted that dishonesty was established in relation to the concealment of the incident, which further undermines trust in the profession.

Accordingly, Mr Kabasinskas submitted that all four limbs are engaged.

Mr Kabasinskas referred to the case of *Nicolas-Pillai v GMC* [2009] EWHC 1048 (Admin), submitting that the panel could take into account other material at the impairment (and sanction) stages, including material (whether positive or negative) which is not the subject of the allegations. He submitted that the attitude of the registrant can be taken into account. He also referred to the cases of *Cohen* and *GMC v Awan* [2020] EWHC 1553 (Admin), the latter concerning insight.

Mr Kabasinskas submitted that misconduct involving dishonesty and safeguarding failures is not easily remediable. He noted your reflective statement but argued that your insight remains limited in that:

- You did not self-report;
- You minimised your actions;
- Your reflections lacked depth; and
- You sought to shift blame, for example, blaming Patient A and alleging that Witness 1 had doctored the Datix form.

Mr Kabasinskas accepted that some training certificates had been provided, but submitted that they were insufficient to demonstrate meaningful remediation of the underlying attitudinal concerns. Accordingly, he submitted that there remains a risk of repetition.

Mr Kabasinskas submitted that you continue to present a risk to patient safety, given your limited insight and the absence of full remediation.

Mr Kabasinskas further submitted that, even if the panel considered the risk of repetition low, the seriousness of the misconduct, including dishonesty and failure to safeguard a vulnerable patient, requires a finding of impairment to uphold professional standards and maintain public confidence in the profession.

Therefore, Mr Kabasinskas invited the panel to find that your fitness to practise is impaired as a result of your misconduct.

Dr Akinoshun submitted that the key question for the panel is whether your fitness to practise is currently impaired, not whether it was impaired at the time of the incident.

In *Cohen*, the Court confirmed that panels must consider factors such as your previously unblemished record, whether the misconduct is easily remediable, whether it has been remedied, and the risk of repetition. Similarly, in *Zygmunt v*

GMC [2008] EWHC 2643 (Admin), the Court stressed that impairment is a current question.

Dr Akinoshun submitted that the relevant factors in your case are:

- Unblemished record
    - Dr Akinoshun submitted that you qualified in 2019 and had an unblemished professional and personal history. The NMC has not disputed your good character.

- Isolated incident
    - The misconduct was a single episode, not part of a wider pattern, and has not been repeated in the five years which is elapsed since the incident.

- Your practice since the incident
    - You continued at East London NHS Foundation Trust until you resigned in October 2021, without restriction, and with no concerns raised, including acting as senior nurse in charge of shifts.
    - You then returned to agency work with London Healthcare Locums for three years, where you practised safely and competently, with no complaints or safeguarding concerns.
    - References confirm your professionalism and reliability during this period.

- Delay in the case
    - Dr Akinoshun submitted that although the case has taken nearly five years to reach this stage, you have demonstrated throughout that time that you are capable of safe and effective practice, without repetition of misconduct.

- Insight and remediation

- You have provided an updated reflective statement, accepting responsibility, acknowledging the seriousness of dishonesty, and reflecting on the impact of your actions on Patient A, colleagues, your employer, and the NMC.
- You have undertaken relevant training including person-centred care, safeguarding, effective communication, and escalation of concerns, with certificates provided.
- You now show greater awareness of de-escalation and safeguarding duties, which demonstrates genuine learning.

- Public protection
  - Dr Akinoshun submitted that your safe practice with vulnerable patients over five years demonstrates that you present no current risk to patients.

- Public interest
  - While public confidence in the profession is important, it is not undermined where a nurse has:
    - committed a single lapse;
    - practised safely for many years thereafter;
    - shown genuine insight; and
    - remediated the concerns.

Dr Akinoshun submitted that fitness to practise is a forward-looking exercise, not a punishment. He submitted that the question is whether you present a risk today. He highlighted that the evidence shows you do not.

Therefore, Dr Akinoshun submitted that in light of the above, your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor. He reminded the panel as a matter of fact that you qualified in 2019, and this incident happened in November 2020.

Decision and reasons on misconduct

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

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

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

***1.1** treat people with kindness, respect and compassion*

***1.2** make sure you deliver the fundamentals of care effectively.*

***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

***1.5** respect and uphold people's human rights*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

***2.1** work in partnership with people to make sure you deliver care effectively*

***2.6** recognise when people are anxious or in distress and respond compassionately and politely*

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

To achieve this, you must:

***3.4** act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*

8 Work cooperatively

To achieve this, you must:

***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*

***8.7** be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety.*

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

***9.1** provide honest, accurate and constructive feedback to colleagues.*

10 Keep clear and accurate records relevant to your practice.

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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*

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

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

To achieve this, you must:

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*

14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 *raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 *take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

17.3 *have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people*

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

To achieve this, you must:

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

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the conduct proved against you is sufficiently serious to amount to misconduct.

The panel noted that you were the most senior and qualified nurse on duty at the time. However, you had only been in the substantive role for one day and were booked to act as a *'floater'*. You qualified in September 2019, and you began acting up as a Band 6 Clinical Practice Lead in May 2020. In the panel's view that promotion may have been too early in your career. You observed a vulnerable patient being assaulted but failed to take appropriate safeguarding measures. It also noted that you did not inform the doctor of the injury, you failed to record the matter accurately, you did not act as an advocate for the patient, and you failed to ensure that your colleague was prevented from continuing to work with patients.

Furthermore, the panel noted that you took deliberate steps to conceal what had occurred. This included failing to make an accurate Datix entry, not reporting to senior staff, and subsequently maintaining that concealment during internal investigation and proceedings. The panel recognised that dishonesty of this nature is

particularly serious. Dishonesty is always grave, and in this case it was compounded by the fact that it related to safeguarding a vulnerable patient, and thereby undermined trust in the profession and breached a fundamental tenet of nursing practice. The panel gave consideration to the fact that this incident happened when you were newly appointed as a Band 6 Clinical Practice Lead and that your reaction to it may have reflected your inexperience in the role. However, it was mindful that you had been acting up in the role for six months and all healthcare professionals have a responsibility to safeguard patients.

The panel was therefore satisfied that your failures constituted a pattern of concealment, sustained over a period of time and across multiple aspects of your role. These were not simple lapses or errors of judgment. They were deliberate actions and omissions, driven by dishonesty intended to cover up the incident and your failure to respond appropriately.

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

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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.

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" mentioned above.

Applying the *Grant* test, the panel was satisfied that your misconduct placed a vulnerable patient at unwarranted risk of harm. Your misconduct breached fundamental tenets of the nursing profession, including honesty, integrity, safeguarding and the duty of candour and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty of this nature, sustained over time and across different aspects of practice extremely serious.

Regarding insight, the panel considered that although you used the word "*dishonesty*" in your reflective statement and accepted the panel's findings, your understanding of its seriousness and its root causes appears superficial. You have not sought to explain why you acted as you did, and in particular why you concealed

the events of that night and why you continued to do so thereafter, up to and including the hearing. The panel therefore found your insight limited.

The panel was of the view that while certain failures such as documentation or understanding of safeguarding procedures could, in theory, be remediated through training, in this case they were underpinned by dishonesty which was the motivation for many of the allegations found proved. Your dishonesty on that night was the basis of your failures to report and escalate the incident, to inform the doctor of the injury, to put safeguarding measures in place, to remove Colleague A from duty, and to accurately record the incident. The panel determined that dishonesty is often attitudinal in nature and inherently difficult to remediate.

The panel noted that you undertook the courses before the fact-finding stage. The panel was of the view that you have not explained how you have applied the learning from these courses to your practice.

In view of all the above the panel found your remediation limited.

In light of the limited insight and remediation, the panel was not satisfied that you have fully addressed your dishonesty. It therefore found that there is a risk of repetition should you be faced with similar or other challenging circumstances. The panel decided that a finding of impairment is necessary on the grounds of public protection.

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 proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds was required because dishonesty of this nature, sustained over time and across different aspects of practice, inevitably undermines public confidence in the profession.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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 striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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.

Submissions on sanction

Mr Kabasinskas submitted that the starting point is the NMC's Sanctions Guidance (VNM-CS Fitness to Practise Library), particularly the section on factors to consider before deciding on sanction (SAN-1). He reminded the panel that the overarching principle is public protection. He submitted that in applying proportionality, the panel must ask: what action is necessary to protect the public, maintain confidence in the profession, and uphold proper standards of conduct and behaviour?

Mr Kabasinskas submitted that the following are relevant:

Aggravating features:

- Conduct which placed patients at serious risk of harm.
- Breach of the professional duty of candour.

- Limited or lack of insight. While developing insight can mitigate, in this case your limited insight is an aggravating feature.
- A rejected defence of honesty.

Mitigating features:

- Early admissions to some charges.

Mr Kabasinskas further submitted that personal mitigation is of limited relevance in regulatory proceedings, where the focus is public protection, not punishment. He submitted that while you have no previous fitness to practise history, this cannot outweigh the seriousness of dishonesty and attitudinal concerns.

Mr Kabasinskas submitted that the panel must consider sanctions in ascending order:

- No Further Action / Caution: Mr Kabasinskas submitted these are not appropriate, given your limited insight, the risk of repetition, and the seriousness of the misconduct.
- Conditions of Practice: Mr Kabasinskas submitted that this sanction is designed to address clinical deficiencies, not dishonesty or attitudinal issues, and would not address public confidence.

Mr Kabasinskas referred the panel to the Sanctions Guidance on Particularly Serious Cases (SAN-2), in particular the section on cases involving dishonesty, noting that dishonesty strikes at the heart of nursing practice. He submitted that dishonesty is always serious, and where it involves concealment, breach of candour and potential harm to vulnerable patients, it will often be incompatible with continued registration. He submitted that you took deliberate steps to conceal events, including:

- Submitting an inaccurate Datix report;
- Failing to notify senior staff;
- Maintaining concealment during investigation.

Mr Kabasinskas submitted that you also denied key facts, alleged the Datix was '*doctored'*, and made serious but unfounded allegations against Witness 1. He submitted that this conduct elevates the seriousness of your dishonesty and undermines your trustworthiness. He referred to the case of *Sawati v GMC* [2022] EWHC 283 (Admin) and submitted that the panel should consider the type of dishonesty and the criteria listed in the SG on dishonesty cases in SAN-2, which reflect the judgment in *Sawati.*

Mr Kabasinskas submitted (relying on *PSA v NMC and Kadiatu Jalloh* [2023] EWHC 3331 (Admin)), that the panel must ask itself whether your conduct is fundamentally incompatible with your remaining on the register, before considering the NMC guidance on suspension. He argued that it is incompatible: this was not a lapse, but deliberate concealment of an incident involving actual or potential harm to patients, compounded by dishonesty and lack of candour.

Mr Kabasinskas submitted that the criteria for suspension under SAN-3d are not met:

- The case is not limited to a single lapse;
- It raises attitudinal concerns;
- There is a risk of repetition given your limited insight;
- Suspension would not reflect the seriousness of the dishonesty or protect public confidence.

In considering SAN-3e, Mr Kabasinskas submitted that strike-off is the only proportionate outcome. He invited the panel to answer the three questions in the following way:

- Do the concerns raise fundamental questions about professionalism? Yes.
- Can public confidence in the profession be maintained if you remain on the register? No.

- Is strike-off the only sanction sufficient to protect patients and uphold standards? Yes.

Mr Kabasinskas submitted that your misconduct, involving dishonesty, concealment, breach of the duty of candour, and failure to prioritise patient safety, is fundamentally incompatible with continued registration. He submitted that a suspension order would not be sufficient.

Accordingly, Mr Kabasinskas invited the panel to impose a striking-off order as the only sanction capable of protecting the public, maintaining confidence in the profession, and upholding proper professional standards. He concluded by reminding the panel of the case of *GMC v Khetyar* [2018] EWHC 813 (Admin), which emphasises that the sanctions guidance is an '*authoritative steer'* to regulatory panels. He submitted that departing from it requires substantial, case-specific justification. He submitted that a generalised assertion that striking-off is disproportionate would not be sufficient in this case.

Dr Akinoshun submitted that the panel has already determined that your fitness to practise is impaired, and its task is now to identify a sanction that is proportionate and necessary to meet the overarching objective of public protection.

Dr Akinoshun referred the panel to the Sanctions Guidance and reminded it that the sanction must be proportionate; it should interfere with your practice no more than is necessary to protect the public, uphold confidence in the profession, and maintain standards. He submitted that the least restrictive sanction that achieves these aims should be imposed.

Dr Akinoshun emphasised that the principal purpose of a sanction is not punitive. He submitted that protection of the public also includes enabling the safe return to practice of experienced practitioners where appropriate, recognising the benefit to the public of their skills and service.

Dr Akinoshun submitted that sanctions must be considered in light of all relevant aggravating and mitigating features. He put forward the following:

Mitigation:

- You have provided a reflective statement, acknowledging the impact of your conduct on Patient A, colleagues, and the profession.
- You have accepted the panel's findings and do not seek to go behind them.
- There has been no repetition of dishonesty or misconduct since the incident in November 2020, despite working in similar and challenging environments until May 2025.
- You have undertaken relevant training in safeguarding, patient-centred care, needs assessment, and communication, and have applied this in agency roles.
- A positive reference from your former employer which attests to your safe and competent practice over a period of years.
- You have engaged fully with the NMC proceedings, have no prior regulatory history, and this was an isolated incident.

Aggravating features acknowledged:

- The original misconduct exposed a vulnerable patient to risk of harm.
- There was a breach of the professional duty of candour.
- The panel has found your insight and remediation is limited.

Dr Akinoshun submitted that you accept these findings but ask the panel to recognise the steps you have already taken, and your commitment to further development.

Dr Akinoshun submitted that at the time of the incident, you were newly qualified, having only 14 months' post-registration experience. He submitted that you lacked senior support during an exceptionally difficult shift, which contributed to your poor judgment. He informed the panel that since then, you have gained substantial experience over nearly six years on the register. He submitted that you have worked competently and safely across acute and intensive psychiatric settings without

incident. [PRIVATE]. Dr Akinoshun submitted that while personal hardship is not determinative, it is relevant context when assessing the proportionality of any sanction.

Dr Akinoshun submitted that sanctions should be considered in ascending order:

- No Further Action / Caution: Dr Akinoshun submitted that these would not adequately protect the public or maintain confidence, given the seriousness of dishonesty.
- Conditions of Practice: Dr Akinoshun submitted that these are not suitable for dishonesty cases, which are attitudinal rather than clinical in nature.
- Suspension: Dr Akinoshun submitted that suspension is the proportionate sanction. This case involves a single incident, with no repetition in nearly five years of subsequent practice. He submitted that there is evidence of developing insight and remediation, albeit limited. He submitted that suspension would mark the seriousness of the misconduct while leaving open the possibility of safe return to practice.
- Striking-Off: Dr Akinoshun submitted that a striking-off order is reserved for cases where conduct is fundamentally incompatible with continued registration. He submitted that, in light of your subsequent safe practice, reflective work, and the absence of further concerns, this case does not fall into that category.

Dr Akinoshun reminded the panel that you have already been subject to an interim suspension order since 9 May 2025, a period of almost five months. He submitted that a suspension order of three to six months would be sufficient and proportionate, providing a structured opportunity for you to further develop your insight and remediation before review.

For all these reasons, Dr Akinoshun submitted that the panel should impose a suspension order of limited duration rather than a striking-off order. He submitted that this would protect the public, uphold confidence in the profession, and give you a fair opportunity to demonstrate your progress at review.

The panel accepted the advice of the legal assessor. He reminded the panel that it should be careful to have regard to its factual findings, recorded in the determination, in respect of the proposition that it should take into account the rejected defence of honesty.

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 including, in particular, SAN-1, SAN-2, SAN-3d, and SAN-3e. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- You deliberately concealed that Patient A had been punched by a Colleague and sustained a visible injury;
- You acted dishonestly by omitting this from your Datix form and seclusion authorisation;
- You sought to shift blame onto Patient A, suggesting their behaviour was the cause;
- You attempted to undermine the credibility of Witness 1 and alleged that the Datix form had been '*doctored'*. The panel found it to be genuine;
- Your dishonesty was prolonged. You initially admitted seeing Colleague A punch Patient A and that you did not act appropriately. However, in your oral evidence, you attempted to retract this admission, claiming that the incident happened so quickly you could not fully comprehend what had happened;
- The misconduct occurred in relation to a vulnerable patient and created a serious risk of harm, not only to Patient A but also to other patients on the ward (because Colleague A was not removed from duty);

- Your insight remains limited. While you have produced a reflective statement, the panel found it superficial and inconsistent with your oral testimony. You failed to explore your motivations for your dishonesty.

The panel also considered the '*rejected defence'* submission put forward by Mr Kabasinskas based on the case of *Sawati*. In particular, the panel noted a passage from that judgment as follows:

> *'…Not telling the truth to the Tribunal', when not freshly charged in separate proceedings as akin to perjury, has to amount to something more than a failure to admit to an allegation (especially a secondary allegation of dishonesty) or a putting to proof, before it can properly count against a doctor. It is likely to have to amount to more than offering an 'honest' alternative explanation of events alleged to be explicable as dishonesty, or it is hard to see how a dishonesty charge is to be effectively defended. It is going to require some thought to be given to the nature of the rejected defence. Was it a blatant and manufactured lie, a genuine act of dishonesty, deceit or misconduct in its own right? Did it wrongly implicate and blame others, or brand witnesses giving a different account as deluded or liars? Or was it just a failed attempt to tell the story in a better light than eventually proved warranted?'*

The panel noted that you advanced inconsistent accounts, at times maintaining you had seen the punch, admitting charge 1a, and giving oral evidence that you had recorded the incident in the Datix form. At other times, you maintained that you had not witnessed the punch as it happened too quickly. In addition, you sought to undermine the credibility of Witness 1, alleging that the Datix form completed by you, which he produced in evidence, had been '*doctored'* by him. The panel found, based on the video evidence, that it was inconceivable that you did not see the punch, and it found the Datix form produced by Witness 1 to be genuine. In the panel's view you deliberately put forward false accounts to avoid taking responsibility for your actions and, in doing so, sought to undermine the integrity of a colleague by alleging that he had manipulated the form which you had originally completed. Your explanations went beyond confusion, or an '*honest alternative explanation of events*', they were

deliberate attempts to mislead, to cast doubt on the credibility of others, and to protect yourself. The panel considered this a further aggravating factor.

The panel also took into account the following mitigating features:

- You made early written admissions to aspects of the misconduct.
- You engaged with the proceedings and have expressed remorse.
- You have provided positive testimonials.
- You have undertaken four relevant training courses in March 2025, although the panel was not persuaded that you took significant learning from them.
- You were working in a difficult and stressful environment at the time of the incident, and you were relatively inexperienced.
- You have worked without further incident for five years, albeit while this case was pending.

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 then considered the imposition of a caution order. However, it determined that, given that your misconduct was not isolated or minor but extremely serious, involving dishonesty, a breach of the duty of candour and a failure to safeguard vulnerable patients, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. 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 was of the view that there

are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining or supervision. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public, since the concerns were attitudinal and involved dishonesty, which cannot be addressed through conditions.

The panel then carefully considered whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where misconduct, while serious, is not '*fundamentally incompatible*' with continued registration and where there is evidence that the registrant can develop sufficient insight. In your case, the dishonesty was not a one-off lapse but a sustained concealment of a witnessed assault, compounded by subsequent attempts to mislead the panel. Your reflective statement did not convince the panel that you have developed any real depth of insight. The panel was not reassured that you are capable of remedying these attitudinal failings within a defined period of suspension.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel determined that the breaches of fundamental tenets of the profession, evidenced by your actions, are fundamentally incompatible with you remaining on the register.

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

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *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?*

Your actions represented significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious: you failed to safeguard vulnerable patients, you attempted to cover up a serious incident, you acted dishonestly on more than one occasion including before this panel, and you have continued to demonstrate limited insight. The panel was of the view that to allow you 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. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this sanction would be sufficient in this case.

The panel recognised that this decision would have a profound impact on you [PRIVATE].

However, the panel considered that this order is necessary to maintain 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 you in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific

circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your 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 Kabasinskas who submitted that pursuant to Rule 24(14), the panel should make an interim suspension order. He reminded the panel that while a substantive sanction has been imposed today, that sanction does not take effect immediately. There is a statutory 28-day appeal period, and if you appeal to the High Court, the substantive sanction will not take effect until the appeal has been finally determined.

In those circumstances, Mr Kabasinskas submitted that there is a clear need to impose an interim order.

Mr Kabasinskas referred the panel to the principles for interim orders set out in the NMC's Fitness to Practise Library at INT-2. He submitted that while much of that guidance applies to cases at the initial referral stage, he emphasised that the same principles of necessity and proportionality apply at this stage.

He summarised the principles as follows:

- Evidence of a concern – In this case, the panel has already made findings of fact and determined that your fitness to practise is impaired.

- The nature and seriousness of the concern – The panel has already found that the concerns are of the utmost seriousness, involving dishonesty, concealment of a witnessed assault, and a lack of candour.

- Proportionality – Any interim restriction must be no more than is necessary to protect the public and uphold public confidence, but it must also be effective in doing so.

Mr Kabasinskas submitted that an interim suspension order is necessary on two statutory grounds:

- Public Protection: The panel has already determined that there is a risk of repetition. He submitted that allowing you to practise without restriction, even for the statutory appeal period, would place patients at risk. That meets the test of necessity for public protection.

- Public Interest: Mr Kabasinskas submitted that it would seriously undermine public confidence in the profession and in the regulator if a nurse who has been struck off the register for dishonesty and concealment of a patient assault were permitted to continue practising unrestricted while awaiting the outcome of an appeal.

Mr Kabasinskas submitted that 18 months is the appropriate duration. He submitted that if no appeal is lodged, the substantive striking-off order will come into effect after 28 days and the interim order will fall away automatically. However, he submitted that if the matter is appealed, it will proceed to the High Court, where the timetable is outside the control of both the NMC and you. He submitted that an 18-month interim order ensures that public protection and public confidence are preserved for the entirety of that period.

Dr Akinoshun did not make any submissions regarding an interim order and stated that he will not seek to persuade the panel to go against their decision.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the

seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.