Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 6 January – Monday, 27 January 2025
Tuesday, 24 June – Friday, 27 June 2025
Monday, 1 September – Wednesday, 3 September 2025

Virtual Hearing

Name of Registrant:	**Adekemi Adefidiya**
NMC PIN:	03K0649O
Part(s) of the register:	Nurses part of the register Sub part 1 RN1: Adult nurse (level 1) - 18 November 2003
Relevant Location:	London
Type of case:	Misconduct and Lack of competence
Panel members:	Janet Fisher (Chair, lay member) Rosalyn Mloyi (Registrant member) Carson Black (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	John Kennedy (6 January, and 1 September – 3 September 2025) Stanley Udealor (7 January – 27 June 2025)
Nursing and Midwifery Council:	Represented by Rebecca Butler, Case Presenter (6 January – 27 June 2025) Vida Simpeh, Case Presenter (1 September – 3 September 2025)
Ms Adefidiya:	Present and represented by Dr Abbey Akinoshun
Facts proved by admission:	Charges 1d, 1e, 1h, 3, 12b, 14a, 14b, 16a, 16b, 16c (i), 16c (ii), 16c (iii) and 17
No case to answer:	Charges 2b and 4c
Facts proved:	Charges 1a, 1b, 1c, 2a, 2c, 2d, 2e, 2f, 4a, 4b, 5, 6, 7, 8, 9, 10, 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v),

	11a (vi), 11a (vii), 11a (viii), 11b (i), 11b (ii), 11b (iii), 11b (iv), 11c (i), 11c (ii), 11c (iii), 11c (iv), 11c (v), 12a, 12c, 12d, 13a, 13b, 13c, 13d, 18 and 19
Facts not proved:	Charges 1f, 1g, 14c and 15
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge (as read)

That you, a registered nurse

1. Whilst caring for Patient A on 5 and 6 February 2019:
    a. did not take all the hourly observations
    b. did not undertake the emergency checks
    c. did not undertake auscultation every 2 hours
    d. changed the setting on the non-invasive positive pressure ventilation ('NIPPY') machine from EPAP 7 to 6
    e. changed the 'NIPPY' EPAP setting against the care plan without authorisation

2. On the 5 and 6 February 2019 did not complete Patient A's records for:
    a. auscultation
    b. fluids
    c. blood pressure
    d. the rationale for changes to the NIPPY settings
    e. emergency checks

3. On 5 February 2019 recorded the incorrect ventilation pressure on the handover and observation chart

4. On 6 February 2019 failed to identify and/or act on Patient A
    a. not receiving sufficient ventilation
    b. increased blood pressure
    c. incorrect tidal volumes

5. On the 5 and 7 October 2018, worked shifts as a nurse for Homerton Hospital while in receipt of sick pay from Barts Health NHS Trust

6. Your actions at charge 5 were dishonest in that you represented to Barts Health NHS Trust, that you were entitled to receive sick pay when you knew you were not.

7. On 10 October 2018, emailed Colleague A, your line manager stating the enclosed time sheets were for shifts from ages ago that had not been paid.

8. Your actions at charge 7 were dishonest in that you sought to mislead Colleague A, to believe the timesheets were not for 5 and 7 October 2018.

9. On 30 May 2019 stated to Colleague B, you had not worked at Homerton Hospital on 5 and 7 October 2018, when in fact you had.

10. Your actions at charge 9, were dishonest in that you sought to deceive Colleague B, into believing you had not worked for Homerton Hospital on 5 and 7 October 2018.

11. That you, between 5 December 2016 and 29 June 2019 whilst employed as a Band 5 nurse at Barts Health NHS Trust in ICU failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse for Level 2 and 3 critical care patients in that you:

    a. Whilst subject to a probationary period between 5 December 2016 and 24 July 2017 failed to meet the following objectives:
        i. Documentation
        ii. Communication
        iii. Time management and organisation
        iv. Basic care
        v. Patient Assessment
        vi. Safe care of level 2 and level Patients
        vii. Complete 125 essential skills in step 1 competencies
        viii. Complete all IV competencies

b. Whilst subject to an informal capability process period between 24 July 2017 and 12 January 2018 failed to meet the following objectives
    i. Follow unit guidelines, implementing policies and procedures correctly
    ii. Time management and organisation
    iii. Documentation (timing and accuracy)
    iv. Clear and effective communication

c. Whilst subject to a formal capability process between 12 January 2018 and 28 June 2019 failed to meet the following objectives:
    i. Follow unit guidelines, implementing policies and procedures correctly. Time management and organisation
    ii. Documentation (timing and accuracy
    iii. Clear and effective communication
    iv. Re-assessment of certain 0–6-month competencies of ventilation, serring up and care of transducers, pharmacology and drug administration and cardiovascular system

12. Between July 2019 and 6 March 2020 when applying and/or accepting the role of a Band 5 Staff Nurse at Royal Papworth Hospital failed to declare
    a. your employment at St Bartholomew's Hospital and/or
    b. being under a capability process whilst employed at St Bartholomew's Hospital and/or
    c. being issued with a final written warning for gross misconduct by St Bartholomew's Hospital and/or
    d. your referral to the NMC

13. Your conduct at charge 12 was dishonest in that you intended to mislead the Royal Papworth Hospital as to your
    a. previous employment with St Bartholomew's Hospital
    b. previous capability concerns

c. a final written warning
d. the NMC referral

14. Breached an Interim Conditions of practice order which was first imposed on 25 August 2020 by the Investigation Committee of the Nursing and Midwifery Council in that you:
    a. failed to disclose to Zentar Healthcare that you were subject to an interim conditions of practice order and/or provide them with the conditions.
    b. on 30 September 2020 worked for St John and St Elizabeth Hospital and failed to disclose that you were subject to an interim conditions of practice order and/or provide a copy of the conditions
    c. withheld your NMC PIN from St John and St Elizabeth Hospital induction sheet on 30 September 2020

15. Your actions set out at charge 14c above were dishonest in that you sought to mislead St John and St Elizabeth Hospital and/or undertake work without restriction.

16. On the 30 September 2020 worked an agency shift at St John and St Elizabeth Hospital and breached an interim conditions of practise order which was first imposed 25 August 2020 by the Investigating Committee of the Nursing and Midwifery Council in that you:
    a. breached condition 1, by not limiting your practice to St Thomas' Hospital
    b. breached condition 2, by working bank and/or agency shifts. breached condition 3, by working without supervision of another registered nurse that ought to have consisted of
        i. working on a supernumerary basis while undertaking and completing three months' probation as a new starter at St Thomas' Hospital
        ii. working at all times on the same shift, as but not always direct observed by, another registered nurse

iii. monthly meetings with your line manager to discuss your conduct and clinical competencies.

17. Worked 10 shifts at various hospitals as set out I schedule 1 in breach of the interim conditions of practice order imposed on 25 August 2020.

And that in light of the above your fitness to practise is impaired by reason of your misconduct at charges 1 to 10, 12-17 and lack of competence at charge 11.

Schedule 1

a. 27 August 2020 Princess Grace Hospital
b. 28 August 2020 London Bridge Hospital
c. 1 September 2020 Wellington Hospital
d. 4 September 2020 Wellington Hospital
e. 8 September 2020 Wellington Hospital
f. 8 September 2020 Wellington Hospital
g. 13 September 2020 Bupa Cromwell Hospital
h. 17 September 2020 London Bridge Hospital
i. 25 September 2020 Royal Brompton Hospital
j. 27 September 2020 Chelsea and Westminster Hospital
k. 30 September 2020 St John and St Elizabeth's Hospital

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Butler, on behalf of the Nursing and Midwifery Council (NMC), to amend the following in charge 17:

*'17. Worked ~~10~~ **11** shifts at various hospitals as set out I schedule 1 in breach of the interim conditions of practice order imposed on 25 August 2020.'*

Ms Butler submitted that the proposed amendment is necessary to correct a typographical error in the wording of the charge to properly reflect the schedule, which enumerated eleven shifts, not ten.

Dr Akinoshun, on your behalf, did not oppose the application.

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, on its own volition, also proposed further amendments to schedule 1, sections (e) and (f), as below. This was to provide clarity that these were two different shifts on the same day. These amendments were not opposed by Ms Butler and Dr Akinoshun.

> *'e. 8 September 2020 Wellington Hospital **ITU North***
> *f. 8 September 2020 Wellington Hospital **ITU South'***

The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Background

The NMC received four referrals with respect to your conduct as a registered nurse which are outlined below.

The first referral that the NMC received was dated 15 February 2019 from Witness 1, wife of Patient A, in relation to the care provided by you to Patient A, whilst working for Thornbury Community Services ('TCS') on the day shifts of 5 and 6 February 2019, in the 48 hours prior to Patient A's death on 7 February 2019. Patient A had motor neurone disease and was being provided with palliative care at home which included non-invasive ventilation. Patient A had a prescription for the EPAP (expiratory positive airway pressure) setting to be between 7 and 8. It was alleged by Witness 1 that you had changed the setting on the non-invasive positive pressure ventilation ('NIPPY') machine from EPAP 7 to 6, and Patient A did not receive ventilation as per his care plan. Witness 1 further alleged that you failed to undertake auscultation every two

hours for Patient A, conduct hourly observations and undertake emergency checks for him. It was further alleged that you failed to complete accurate records for Patient A with respect to those observations. Witness 1 alleged that your conduct contributed to Patient A's deterioration and subsequent death on 7 February 2019.

The allegations were investigated by TCS and your employment was terminated on 2 June 2019, for breach of contract.

The matter was referred to the police for investigations as well as the coroner, but no further action was taken by them.

The NMC received a second referral on 10 February 2020 from Barts Health NHS Trust (Barts), where you were employed as a staff nurse from 5 December 2016 to 28 July 2019. It was alleged that you had worked agency shifts on 5 and 7 October 2018 at Homerton Hospital Intensive Care Unit (ICU), whilst on sickness absence from St Bartholomew's Hospital. During this period, it was alleged that you were under performance/capability management due to concerns as to your competencies in intensive care nursing. It was further alleged that you had failed to meet the required minimum standards of care for Level two and Level three critical care patients (as set out by the Intensive Care Society).

The NMC received a third referral on 4 May 2020 from the Royal Papworth Hospital (Papworth) alleging that you had applied for a role in July 2019 without disclosing: your employment at Barts, capability proceedings, that you had received a final written warning for gross misconduct at Barts and your referral to the NMC. Royal Papworth Hospital only became aware of the employment and the previous capability proceedings on receipt of the NMC interim order decision dated 6 March 2020. The Hospital had conducted a disciplinary investigation into the allegations and dismissed you on 24 April 2020.

The NMC received a fourth referral from St John & St Elizabeth Hospital (St Johns) regarding potential breaches of the interim conditions of practice order imposed by a Fitness to Practise panel on 25 August 2020 in relation to working bank and agency shifts namely breaching:

‘1. You must limit your nursing practice to the St Thomas’ Hospital.

2. You must not work Bank or Agency shifts.

3. You must ensure that you are supervised by another registered nurse any time you are working. Your supervision must consist of:

• Working on a supernumerary basis while undertaking and completing three months’ probation as a new starter at St Thomas’ Hospital.

• Working at all times on the same shift as, but not always direct observed by, another registered nurse

• monthly meetings with your line manager to discuss your conduct and clinical competencies’

It was alleged that you had worked an agency shift for Zentar Healthcare (Zentar) at St Johns on 30 September 2020 in breach of the interim conditions of practice order. It was further alleged that you also withheld your NMC registration ‘*PIN*’ in the induction paperwork that required completing at the start of the shift. The nurse in charge of that shift discovered that you were subject to an interim conditions of practice order later in the shift, after you provided your ‘*PIN*’ when reminded. It was also alleged that you had worked other shifts for Zentar at various hospitals outlined in Schedule 1.

In the course of the NMC investigations, it was discovered that you had allegedly worked as an agency nurse on the Intensive Care Units and community settings at Schedule 2, between 1 October 2018 and 30 September 2020, knowing that you had been placed on Supernumerary Practice since 30 August 2018 at St Bartholomew’s Intensive Care Unit having failed to achieve your ICU Step 1 competencies by July 2017 and having further failed to achieve your capability process objectives by June 2019.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Butler under Rule 31 to admit the following into evidence:

1. Thornbury Community Services documentation from Colleague C

2. Statement from Colleague C dated 25 July 2019.
3. Interview notes with Colleague C dated 30 August 2019.

Ms Butler referred the panel to Rule 31 and submitted that it is an established principle of law that a panel could admit hearsay evidence subject to the test of relevance and fairness. She informed the panel that the hearsay evidence of Colleague C was in relation to charges 1, 2, 3, and 4 in their entirety.

Ms Butler submitted that the hearsay evidence of Colleague C is relevant in these proceedings as Colleague C and you were respectively the nurses in charge of the care of Patient A on your shifts from 5 February 2019 until his death on 7 February 2019. She stated that whilst you worked on day shifts during that period, you handed over to Colleague C for night shifts at that time. Ms Butler highlighted that Colleague C was the nurse in charge at the time that Patient A passed away and he provided relevant accounts of events between 5 – 7 February 2025. Ms Butler took the panel through relevant aspects of Colleague C's hearsay statements.

Ms Butler referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). She highlighted that this case laid out the following factors to be considered in admitting hearsay evidence:

(i) 'Whether the statements are the sole or decisive evidence in support of the charges
(ii) The nature and extent of the challenge to the contents of the statements
(iii) Whether there was any suggestion that the witnesses had reasons to fabricate their allegations
(iv) The seriousness of the charge, taking into account the impact which adverse findings might have on the Registrant's career
(v) Whether there is a good reason for the non-attendance of the witness
(vi) Whether the NMC have taken reasonable steps to secure attendance
(vii) Whether the Registrant had prior knowledge that the witness statements were to be read'

Ms Butler submitted that Colleague C was also investigated by TCS as well as the NMC in respect of his involvement in the death of Patient A and therefore the NMC decided that it would not be reasonable to call him as a witness in these proceedings. She submitted that there was a risk if Colleague C was called to give evidence in these proceedings, he may prejudice your case. She submitted that this may impact negatively on the fairness of these proceedings. Ms Butler further submitted that Colleague C was no longer engaging with the NMC and had not responded to various attempts by the NMC to contact him.

Ms Butler submitted that the statements of Colleague C are not the sole or decisive evidence with respect to charges 1, 2, 3 and 4 in their entirety. She submitted that Witness 1 had provided a witness statement, relevant exhibits and had also given oral evidence with respect to charges 1, 2, 3 and 4 in their entirety.

Ms Butler highlighted that you had denied charges 1, 2, 3 and 4, and the panel would hear the submissions of Dr Akinoshun in relation to the nature and extent of your challenge to the hearsay evidence. She also submitted that the NMC had notified you that there would be a hearsay application with respect to the evidence of Colleague C.

Ms Butler submitted that there is no evidence to suggest that Colleague C had fabricated his statements given that those statements were contemporaneously made in the course of TCS' investigation and neither the police nor the NMC were yet involved in the investigation.

Ms Butler submitted that charges 1, 2, 3 and 4 related to record-keeping errors and therefore they are low level misconduct charges, which, if found proved in isolation, would not have a major negative impact on your nursing career.

In conclusion, Ms Butler submitted that the test set out in Rule 31 has been satisfied and it is therefore fair and relevant for the respective statements of Colleague C to be admitted into evidence.

Dr Akinoshun stated that you do not oppose the hearsay application. He submitted that the hearsay evidence of Colleague C is not the sole or decisive evidence with respect to charges 1, 2, 3 and 4 in their entirety. He further submitted that the hearsay evidence of Colleague C is fair and relevant in these proceedings. He highlighted that Ms Butler had already addressed the panel on the reasons for the non-attendance of Colleague C.

In conclusion, Dr Akinoshun submitted that you are neutral in the hearsay application made by the NMC and it is a matter for the panel to decide whether to admit the hearsay evidence of Colleague C.

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

The panel considered the hearsay application.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel considered whether the evidence of Colleague C is the sole or decisive evidence with respect to charges 1, 2, 3 and 4 in their entirety. The panel took into account that there is other evidence which had been presented by the NMC in support of charges 1, 2, 3 and 4 including the witness statement of Witness 1 and her relevant exhibits. It also noted that Witness 1 had earlier attended the hearing to give oral evidence on the allegations. The panel also had sight of some of the relevant clinical records of the incidents. The panel therefore decided that the evidence of Colleague C is not the sole or decisive evidence with respect to charges 1, 2, 3 and 4 in their entirety.

The panel noted that the NMC had made you aware that there would be a hearsay application with respect to the evidence of Colleague C. The panel took into account that you did not challenge the hearsay application of the NMC to admit these documents into evidence. Furthermore, the panel noted that it was common ground

between the parties that there was no suggestion that Colleague C had fabricated his evidence.

The panel considered the charges to be serious and any adverse finding could have a negative impact on your nursing career.

The panel considered the reasons provided by the NMC for the non-attendance of Colleague C. The panel accepted the submissions of Ms Butler and it was satisfied that sufficient reasons had been provided by the NMC for the non-attendance of Colleague C as a witness in this hearing.

The panel took into consideration that the respective statements of Colleague C were obtained through a formal fact-finding process by TCS and were contemporaneously made in the course of the investigation. Accordingly, the panel was satisfied that the respective written and oral statements of Colleague C were obtained through a formal investigation process, and therefore likely to be accurately recorded. The panel determined that they are relevant to issues in these proceedings.

Having considered these factors, the panel determined that the evidence of Colleague C is relevant and it would be fair to admit the respective statements of Colleague C into evidence. The panel would give what it deems appropriate weight once it had heard and evaluated all the evidence.

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

Ms Butler made an application that matters relating to Witness 6's [PRIVATE], which may be explored in the course of her evidence, be held in private. The application was made pursuant to Rule 19 of the Rules.

Dr Akinoshun did not oppose the application.

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 accepted the advice of the legal assessor.

The panel determined to hold this hearing partly in private. It will go into private session as and when matters relating to Witness 6's [PRIVATE] are raised in order to protect her privacy.

Decision and reasons on application to admit additional hearsay evidence

The panel heard an application made by Ms Butler under Rule 31 to admit the following into evidence:

1. Note of telephone call with Colleague D dated 17 May 2021
2. Record of Updates from Colleague D (further information request) dated 5 July 2023.
3. Communication log of telephone call with Colleague E dated 29 September 2023.

Ms Butler referred the panel to Rule 31 and the case of *Thorneycroft* as relevant factors to be considered in admitting hearsay evidence.

In relation to the evidence of Colleague D, Ms Butler highlighted that Colleague D was the head of AMC Professionals, which was the nursing agency that had assigned shifts to you at Homerton Hospitals on 6 and 7 October 2018. She asserted that the evidence of Colleague D is not the sole or decisive evidence with respect to charges 5 and 6. She submitted that the NMC had provided other evidence to support charges 5 and 6 including your agency timesheets for Homerton Hospital work shifts and the evidence of witnesses 4 and 5.

Ms Butler highlighted that you had denied the allegations but you have not provided any formal defence statement. She also submitted that the NMC had notified you

prior to this hearing that there would be a hearsay application with respect to the evidence of Colleague D.

Ms Butler submitted that there is no evidence to suggest that Colleague D had fabricated his hearsay evidence. She submitted that the allegations are serious and would have an adverse effect on your nursing career if found proven. She referred the panel to the Record of Updates from Colleague D (further information request) dated 5 July 2023 and she submitted that the Record demonstrated several attempts made by the NMC to secure the attendance of Colleague D as a witness and to provide a witness statement. In conclusion, she invited the panel to admit the hearsay of Colleague D into evidence.

With respect to the evidence of Colleague E, Ms Butler highlighted that Colleague E was the Clinical Lead at TCS and it should be noted that you had stated during the local investigations at TCS that Colleague E had authorised you to change the ventilation settings for Patient A. She submitted that; however, Colleague E had denied authorising you to change the ventilation settings for Patient A. This is in relation to charges 1d and 1e.

Ms Butler submitted that the evidence of Colleague E is not the sole or decisive evidence with respect to the issue of whether Colleague E had directed you to change the ventilation settings for Patient A. She submitted that the panel may consider the evidence of Witness 6, the Leicestershire Police Report and the care plan for Patient A, as supporting evidence in relation to this issue. She also referred the panel to the email trail between Colleague E and Witness 1

Ms Butler highlighted that you had denied charges 1d and 1e and therefore the NMC is held to the strict proof of those charges. She submitted that the NMC had notified you prior to this hearing that there would be a hearsay application with respect to the evidence of Colleague E.

Ms Butler submitted that there is no evidence to suggest that Colleague E had fabricated her hearsay evidence. Ms Butler submitted that Colleague E is a nursing

professional and she would know that fabricating any evidence in relation to an ongoing NMC investigation would put her nursing ‘PIN’ at risk.

Ms Butler submitted that the charges are serious and would have an adverse effect on your nursing career if found proven. She submitted that Colleague E was not invited by the NMC to attend the hearing as a witness as the evidence of Colleague E only goes to a discrete issue and the NMC considered that it was disproportionate to invite Colleague E to attend the hearing to address that discrete issue. She submitted that there is other surrounding evidence which could aid the panel to make its findings on charges 1d and 1e, including the evidence of Witnesses 1 and 6. In conclusion, Ms Butler invited the panel to admit the hearsay of Colleague E into evidence.

Dr Akinoshun informed the panel that you do not oppose the NMC application to admit the Note of telephone call with Colleague D dated 17 May 2021 as well as the Record of Updates from Colleague D (further information request) dated 5 July 2023, into evidence.

Dr Akinoshun however submitted that you oppose the admission of Communication log of telephone call with Colleague E dated 29 September 2023, into evidence. He highlighted that the issue of whether Colleague E had directed you to change the ventilation settings for Patient A goes to charges 1d and 1e. He submitted that those charges are very serious and any adverse finding could have a negative impact on your nursing career. He submitted that the NMC has had five years to investigate this case and ought to have invited Colleague E to give evidence as a witness in this hearing.

Dr Akinoshun submitted that although the evidence of Colleague E is relevant, it would amount to unfairness if her hearsay document was admitted into evidence. He asserted that it would deprive you of the opportunity to cross-examine Colleague E given that you had stated that she had authorised you to change the ventilation settings of Patient A. He submitted that the panel would also be deprived of the opportunity to question Colleague E with respect to the contentious issue.

In conclusion, Dr Akinoshun invited the panel to reject the hearsay evidence of Colleague E.

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

The panel considered the hearsay application. It had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence.

In relation to the note of telephone call with Colleague D dated 17 May 2021 and Record of Updates from Colleague D (further information request) dated 5 July 2023, the panel considered whether the evidence of Colleague D is the sole or decisive evidence with respect to charges 5 and 9. The panel took into account that there is other evidence which had been presented by the NMC in support of charges 5 and 9 including the witness statements of Witnesses 4 and 5**,** their relevant exhibits as well as your agency timesheets for shifts worked at Homerton Hospital. The panel also noted that Witnesses 4 and 5 had earlier attended the hearing to give oral evidence on the allegations. The panel therefore decided that the evidence of Colleague D is not the sole or decisive evidence with respect to charges 5 and 9.

The panel noted that the NMC had made you aware that there would be a hearsay application with respect to the evidence of Colleague D. The panel took into account that you did not challenge the hearsay application of the NMC to admit these documents into evidence. Furthermore, the panel noted that it was common ground between the parties that there was no suggestion that Colleague D had fabricated his evidence.

The panel considered the charges to be serious and any adverse finding could have a negative impact on your nursing career.

The panel considered the reasons provided by the NMC for the non-attendance of Colleague D. It noted that there had been subsequent attempts made by the NMC to contact Colleague D but there was no response from him. The panel accepted the submissions of Ms Butler and it was satisfied that sufficient reasons had been provided by the NMC for the non-attendance of Colleague D as a witness in this hearing.

The panel took into consideration that the evidence of Colleague D provides some context to the allegations contained in charges 5 and 9. The panel therefore determined that the evidence of Colleague D is relevant to issues in these proceedings.

Having considered these factors, the panel determined that the evidence of Colleague D is relevant and it would be fair to admit the hearsay documents of Colleague D into evidence. The panel would give what it deems appropriate weight once it had heard and evaluated all the evidence.

With respect to the Communication log of telephone call with Colleague E dated 29 September 2023, the panel considered whether the evidence of Colleague E is the sole or decisive evidence in relation to the issue of whether Colleague E had directed you to change the ventilation settings for Patient A. The panel took into account that there was no other supporting evidence from the NMC in relation to this issue. It therefore determined that the evidence of Colleague E is the sole and decisive evidence.

The panel noted that the NMC had made you aware that there would be a hearsay application with respect to the evidence of Colleague E. The panel took into account that you had challenged the hearsay application of the NMC to admit this document into evidence. It considered that you had stated during the local investigations at TCS that Colleague E had directed you to change the ventilation settings for Patient A. The panel noted that this is a direct contradiction to the evidence of Colleague E.

The panel was of the view that there could be potential reasons for Colleague E to fabricate her evidence, given that if your allegation is found proved, it could also

have an adverse impact on the nursing career of Colleague E. In the panel's judgement, the evidence of Colleague E is relevant to the issues in these proceedings given that it is the sole and decisive evidence in relation to whether Colleague E had directed you to change the ventilation settings for Patient A. The panel took into consideration that the allegation is directly linked to charges 1d and 1e. It considered the charges to be serious and any adverse finding could have a negative impact on your nursing career.

The panel considered the reasons provided by the NMC for the non-attendance of Colleague E. It rejected the reason provided by the NMC that it was not reasonable and practicable for Colleague E to attend these proceedings as a witness to give evidence for a minor issue. The panel considered Colleague E to be a relevant witness in these proceedings given her role at the time of the incidents as a Clinical Lead at TCS. Furthermore, the panel considered the issue of whether Colleague E had directed you to change the ventilation settings for Patient A, to be serious as it is directly related to charges 1d and 1e. In this regard, the panel was not satisfied that there was a good reason for the non-attendance of Colleague E, nor that the NMC had taken all reasonable steps to secure her attendance at the hearing.

Having considered these factors, the panel determined that it is not fair to admit the hearsay document of Colleague E into evidence. Accordingly, the hearsay application is hereby refused with respect to the hearsay evidence of Colleague E.

Subsequently, Colleague E attended the hearing to give evidence.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Butler to amend the schedule of charge under Rule 28, and to add additional charges to this case under Rules 29 (3) and 29 (4). She submitted that the amendments involved the alterations of charges 1b, 1d, 1e, 2d, 2e, 3, 4a and 4b, the addition of charges 1f, 1g, 1h, 2f, 18 and 19, as well as the removal of charge 2c. Ms Butler submitted that the proposed amendments would provide clarity and more accurately reflect the evidence.

Ms Butler submitted that she had informed you, through your representative, Dr Akinoshun, from Day 2 of these proceedings of the general nature of the application that would be made by the NMC. Ms Butler asserted that Dr Akinoshun was also provided with details of the proposed charges 18 and 19. She submitted that you have therefore been provided with sufficient notice to enable you to prepare any questions for cross-examination of the witnesses based on the proposed amendments. Ms Butler submitted that there was already relevant information contained within the NMC Exhibit Bundle to support the proposed amendments and the additional charges 18 and 19 are supported by the unchallenged evidence that you were a supernumerary at Barts from August 2018.

The proposed amendments to the charges are as follows:

Charge 1

1. *Whilst caring for Patient A on 5 and 6 February 2019:*
   b. did not undertake the emergency ***equipment*** *checks*

   d. at an unknown time between 1700 and 2000 *changed the setting on the non-invasive pressure ('NIPPY') EPAP from 7 to 6.*
   e. changed the 'NIPPY' EPAP setting to ***6.0*** *against the Care Plan* ***and Ventilation Prescription of 06/11/2018***

   f. on 5 February 2019 failed to maintain the appropriate IPAP pressures on 8 or more occasions contrary to the Care Plan and Ventilation Prescription of 06/11/2018

   g. on 6 February 2019 failed to maintain the appropriate IPAP pressures on 11 or more occasions contrary to the Care Plan and Ventilation Prescription of 06/11/2018

   h. on 5 February 2019, recorded only one blood pressure reading during the course of a 12-hour shift

Ms Butler submitted that the rationale for amending charge 1 was based on the documentary evidence of the hourly observation charts for 5 and 6 February 2019 day shifts. She submitted that the amendments of charges 1b, 1d and 1e are necessary to provide clarification and specificity. She asserted that the additional sub-charges 1f, 1g and 1h were based on the evidence of Witness 6 and the Ventilation Prescription contained in the Awake and Asleep Ventilation Settings document.

Charge 2

> *'2. on the 5 and 6 February 2019, did not complete Patient A's records for:*
>
> *c. ~~blood pressure~~*
>
> *d. the rationale for changes to the NIPPY settings for both IPAP and EPAP*
>
> *e. daily emergency equipment checks*
>
> ***f. Nebulisers administered on 5 February 2019'***

Ms Butler submitted that the rationale for amending charges 2d and 2e is predicated on the clinical records for the day shifts on 5 and 6 February 2019 and provides specificity to the allegations. She asserted that the additional sub-charge 2f was based on the oral evidence of Witness 6 and the observation chart for Patient A. Ms Butler highlighted that Witness 6 had stated that Patient A was expected to have regular normal saline (salt water) nebulisers and it was notable that he went for long periods without it being evidenced on the observation chart. Ms Butler submitted that the removal of charge 2c was due to the fact that the allegation of completing the records for blood pressure was already covered by the proposed charge 1h.

Charge 3

> *3. on 5 February 2019 recorded an incorrect and unprescribed ventilation pressure on the handover and observation chart i**n that you recorded 6.0 for EPAP***

Ms Butler submitted that the rationale for the amendment of charge 3 was to provide clarification and specificity of the allegation. She asserted that the amendment was based on the Shift Handover Form under '*Ventilator Setting Checked'*.

Charge 4

> '4. on 6 February 2019 failed to identify and/or act on Patient A
>
> *a. Not receiving sufficient ventilation* ***in that you maintained his EPAP at 6.0 for the entire shift contrary to the Care Plan and Ventilation Prescription of 06/11/2018***
>
> *b. increased blood pressure* ***of 114/98 at 1200 and 152/87 at 1600 hrs'***

Ms Butler submitted that the rationale for the amendment of charges 4a and 4b was to provide clarification and specificity of the allegation. She further submitted that the amendment would reflect the evidence that there were two ventilators used in the care of Patient A and the handover settings for each of the four work shifts in the care of Patient A. She asserted that the amendment was based on the evidence of Witness 6 and the Ventilation Prescription contained in the Awake and Asleep Ventilation Settings document.

Charges 18 and 19

> ***'18. Between October 1 2018 and 30 September 2020 you worked as an Agency Nurse on the Intensive Care Units and community settings at Schedule 2, knowing that you were at all times placed on Supernumerary Practise since August 30 2018 at St Bartholomew's Intensive Care Unit having failed to achieve your Probationary Step 1 competencies by July 2017 and having failed to achieve your capability process objectives by June 2019.***
>
> ***19. Your actions at 18 were dishonest in that you sought to mislead the agency, hospital intensive care units and community settings employers at Schedule 2 that you were qualified to look after intensive care patients***

when in fact you were at those times only permitted to observe patient care on intensive care settings in a supernumerary capacity.

Schedule 2
5 October 2018 – The Homerton Hospital, ITU
7 October 2018 The Homerton Hospital, ITU
13 January 2019 For TCS Agency caring for Patient A at home
15 January 2019 For TCS Agency caring for Patient A at home
16 January 2019 For TCS Agency caring for Patient A at home
5 February 2019 For TCS Agency caring for Patient A at home
6 February 2019 For TCS Agency caring for Patient A at home
27 August 2020- Princess Grace Hospital, ITU
28 August 2020- London Bridge Hospital, ITU
1 September 2020- Wellington Hospital, ITU North
4 September 2020- Wellington Hospital, ITU South
8 September 2020- Wellington Hospital, ITU North
8 September 2020- Wellington Hospital, ITU South
13 September 2020- Bupa Cromwell Hospital, ITU
17 September 2020-London Bridge Hospital, ITU
25 September 2020- Royal Brompton Hospital, AICU/ITU
27 September 2020-Chelsea and Westminster Hospital, ITU
30 September 2020 - St. John & St. Elizabeth's hospital , ITU/HDU

And that in light of the above your fitness to practise is impaired by reason of your Misconduct at charges 1 to 10, 12 – 19 and Lack of Competence at charge 11.'

Ms Butler submitted that there is unchallenged evidence that on 30 August 2018, you were restricted to supernumerary practice which was renewed and confirmed by Colleague A on 3 January 2019 at St Bartholomew's hospital. Ms Butler asserted that you had never completed your Probationary Step 1 competencies and had always therefore been on supervised practise during capability management or supernumerary practise since 30 August 2018. Ms Butler submitted that the implication of your supernumerary status was that you were never permitted to make

any patient management decisions independently after 30 August 2018 as you were only allowed to observe patient care or be properly supervised by senior nurses who were aware of your clinical limitations.

Ms Butler submitted that the relevant information which demonstrated that you had worked the shifts contained in Schedule 2 was based on the evidence of Colleague F, the Homerton time sheets used in the second investigation at St Barts and the evidence of Witnesses 1 and 6.

In conclusion, Ms Butler submitted that the proposed amendments are proportionate, fair and in the public interest. She reminded the panel that it retains the discretion under Rule 28 to amend or add to any of the charges as it deems appropriate.

Dr Akinoshun did not oppose the alterations to the existing charges 1b, 1d, 1e, 2d, 2e, 3, 4a and 4b or the removal of charge 2c.

However, Dr Akinoshun opposed the proposed addition of charges 1f, 1g, 1h, 2f, 18 and 19 to the schedule of charge. He submitted that such addition of new charges would amount to injustice and cause prejudice to you. He highlighted that the NMC had spent five years investigating this case before it proceeded to a substantive hearing. He submitted that, therefore, the NMC had those five years to review, amend or add additional charges prior to these proceedings. He asserted that there was no reasonable justification for the late hour proposed amendment of the schedule of charge by the NMC.

Dr Akinoshun stated that although Ms Butler had informed him of the proposed amendments on day 2 of the hearing, she did not provide the full details of the amendments and the particularisation of the new charges until day 7 of the hearing.

Dr Akinoshun submitted that such proposed late hour amendment would have deprived you of the opportunity to question the witnesses who had already given their evidence prior to this application. He further submitted that the proposed amendments were disproportionate given that the NMC sought to add serious charges including another allegation of dishonesty.

Dr Akinoshun therefore invited the panel to refuse the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel took account of the submissions made by Ms Butler and those made by Dr Akinoshun with respect to the application to amend the schedule of charge.

Charge 1b

1. Whilst caring for Patient A on 5 and 6 February 2019:
    b. *did not undertake the emergency **equipment** checks*

The panel was of the view that the proposed amendment would provide a degree of specificity to the charge which would enable you to address the allegation accordingly. It noted that the proposed amendment would not have an impact on the seriousness of the charge or the witness evidence. The panel was therefore satisfied that there would be no prejudice to you, nor would any injustice be caused by such amendment. It therefore allowed the amendment.

The panel, of its own volition, further amended the charge by adding the word **'daily'** in order to clarify the charge and to align with charge 2e:

*'did not undertake the **daily** emergency equipment checks'*

Charge 1d

1. Whilst caring for Patient A on 5 and 6 February 2019:
    d. ***at an unknown time between 1700 and 2000** changed the setting on the non-invasive pressure ('NIPPY') EPAP from 7 to 6.*

The panel was of the view that the proposed amendment would provide a degree of specificity to the charge which would enable you to address the allegation

accordingly. It noted that the proposed amendment would not have an impact on the seriousness of the charge or the witness evidence. The panel was therefore satisfied that there would be no prejudice to you, nor would any injustice be caused by such amendment. It therefore allowed the amendment.

The panel, of its own volition, further amended the charge by adding **'on 5 February 2019'** in order to provide clarity to the charge:

> *'**on 5 February 2019, at an unknown time between 1700 and 2000** changed the setting on the non-invasive pressure ('NIPPY') EPAP from 7 to 6'*

Charge 1e

1. Whilst caring for Patient A on 5 and 6 February 2019:
    e. *changed the 'NIPPY' EPAP setting to **6.0** against the Care Plan **and Ventilation Prescription of 06/11/2018***

The panel was of the view that the proposed removal of the phrase '*without authorisation'* is to clarify the nature of the charge.

The panel determined that the inclusion of '*6.0'* and '*and ventilation prescription of 06/11/2018'* would provide a degree of particularity to the charge. It noted that there is relevant information in Patient A's care plan to support the proposed amendment and it would not have significant impact on the witness evidence in this case. The panel was therefore satisfied that there would be no prejudice to you, nor would any injustice be caused by such amendment. It therefore allowed the amendment.

The panel, of its own volition, further amended the charge by replacing the word ***'against'*** with **'*contrary to*'** in order to provide clarity to the charge.

Charges 1f and 1g

1. Whilst caring for Patient A on 5 and 6 February 2019:

f. ***on 5 February 2019 failed to maintain the appropriate IPAP pressures on 8 or more occasions contrary to the Care Plan and Ventilation Prescription of 06/11/2018***

g. ***on 6 February 2019 failed to maintain the appropriate IPAP pressures on 11 or more occasions contrary to the Care Plan and Ventilation Prescription of 06/11/2018***

The panel acknowledged that the addition of charges 1f and 1g at this stage of the proceedings could result in prejudice to your interests in this case. However, it would also enable you to address these allegations directly and for the panel to make specific findings on these issues. The panel noted that the proposed charges would appropriately reflect the evidence in this case and there is relevant information in the NMC Exhibit Bundle that may support these charges. The panel bore in mind its duty to protect the public and it was therefore satisfied that this duty outweighs any prejudice to your interests in this regard. The panel therefore determined that it is in the interest of justice to allow the amendments.

Charge 1h

1. *Whilst caring for Patient A on 5 and 6 February 2019:*
   h. ***on 5 February 2019, recorded only one blood pressure reading during the course of a 12-hour shift***

The panel, of its own volition, amended the charge by replacing the word **'recorded'** with '**took'** in order to appropriately reflect the nature of the allegation:

*'**on 5 February 2019, took only one blood pressure reading during the course of a 12-hour shift**'*

The panel was of the view that its amendment is appropriate in order to make a distinction between the allegation that you had taken only one blood pressure reading during the course of a twelve-hour shift and the suggestion that you took the blood pressure readings but did not record them.

The panel acknowledged that the addition of charge 1h at this stage of the proceedings could result in prejudice to your interests in this case. However, it would also enable you to address the allegation directly and for the panel to make specific findings on this issue. The panel noted that the proposed charge would appropriately reflect the evidence in this case and there is relevant information in the NMC Exhibit Bundle that may support this charge. The panel bore in mind its duty to protect the public and it was therefore satisfied that this duty outweighs any prejudice to your interests in this regard. The panel therefore determined that it is in the interest of justice to allow the amendment.

Charge 2c

2. *On the 5 and 6 February 2019, did not complete Patient A's records for:*
   ~~*c. blood pressure*~~

The panel refused the application to remove charge 2c. The panel was of the view that charge 1h was different from charge 2c in that whilst in charge 1h, the allegation is now that you had taken only one blood pressure reading during the course of a twelve-hour shift. In charge 2c, the allegation is that you did not record the blood pressure readings.

The panel was satisfied that this approach would provide greater clarity and there would be no prejudice to you, nor would any injustice be caused by this charge.

Charges 2d and 2e

2. *On the 5 and 6 February 2019, did not complete Patient A's records for:*
   d. *the rationale for changes to the NIPPY settings* ***for both IPAP and EPAP***
   e. *daily emergency* ***equipment*** *checks*

The panel was of the view that the proposed amendments would provide a degree of particularity to the charges which would enable you to address the allegations

accordingly. It noted that the proposed amendments would not have an impact on the seriousness of the charge or the witness evidence. The panel was therefore satisfied that there would be no prejudice to you, nor would any injustice be caused by such amendments. It therefore allowed the amendments.

Charge 2f

2. On the 5 and 6 February 2019, did not complete Patient A's records for:
   f. ***Nebulisers administered on 5 February 2019***

The panel acknowledged that the addition of charge 2f at this stage of the proceedings could result in prejudice to your interests in this case. However, it would also enable you to address the allegation directly and for the panel to make specific findings on the issue. The panel noted that the proposed charge would appropriately reflect the evidence in this case and there is relevant information in the NMC Exhibit Bundle that may support this charge. The panel bore in mind its duty to protect the public and it was therefore satisfied that this duty outweighs any prejudice to your interests in this regard. The panel therefore determined that it is in the interest of justice to allow the amendment.

The panel, of its own volition, further amended the charge by removing the date *'on 5 February 2019'* as any recording issues are relevant to patient care on both days.

Charge 3

3. *On 5 February 2019, recorded* ***an incorrect and unprescribed*** *ventilation pressure on the handover and observation chart* ***in that you recorded 6.0 for EPAP***

The panel noted that the Shift Handover Form indicates that you had set the ventilation pressure to *'6.0'* and recorded it accordingly. In this regard, the panel, of its own volition, decided to remove the word '*incorrect'* from the charge. Nevertheless, the panel allowed the amendment of the charge to include the words '*an unprescribed'* in order to reflect the issues to be determined in this case. It also

decided that the phrase '*in that you recorded 6.0 for EPAP'* would provide a degree of particularity to the charge which would enable you to address the allegations accordingly.

Charges 4a and 4b

4. *On 6 February 2019 failed to identify and/or act on Patient A*

    a. *Not receiving sufficient ventilation* ***in that you maintained his EPAP at 6.0 for the entire shift contrary to the Care Plan and Ventilation Prescription of 06/11/2018***

    b. *increased blood pressure* ***of 114/98 at 1200hrs and 152/87 at 1600 hrs***

The panel was of the view that the proposed amendments would provide a degree of specificity to the charges which would enable you to address the allegations accordingly. It noted that the proposed amendments would not have an impact on the seriousness of the charge or the witness evidence. The panel was therefore satisfied that there would be no prejudice to you, nor would any injustice be caused by such amendments. It therefore allowed the amendments.

Charges 11a (vi), 11c (v), 16, 17 and Schedule 2

The panel, of its own volition, decided to amend charges 11a (vi), 11c (v), 16, 17 and Schedule 2 in order to correct typographical errors respectively:

'11a (vi). Safe care of level 2 and level ***3*** *Patients*
11c (v). Re-assessment of certain 0–6-month competencies of ventilation, ***setting*** *up and care of transducers, pharmacology and drug administration and cardiovascular system'*

'16c. *breached condition 3, by working without supervision of another registered nurse that ought to have consisted of…'*

*‘17. Worked 11 shifts at various hospitals as set out **in** schedule 1 in breach of the interim conditions of practice order imposed on 25 August 2020.’*

‘Schedule 2

C. 12th January 2019 For TCS Agency caring for Patient A at home
D. 13th January 2019 For TCS Agency caring for Patient A at home
E. 15th January 2019 For TCS Agency caring for Patient A at home’

The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the amendments.

Charges 18 and 19

18. **Between October 1 2018 and 30 September 2020 you worked as an Agency Nurse on the Intensive Care Units and community settings at Schedule 2, knowing that you were at all times placed on Supernumerary Practise since August 30 2018 at St Bartholomew’s Intensive Care Unit having failed to achieve your Probationary Step 1 competencies by July 2017 and having failed to achieve your capability process objectives by June 2019.**

19. **Your actions at 18 were dishonest in that you sought to mislead the agency, hospital intensive care units and community settings employers at Schedule 2 that you were qualified to look after intensive care patients when in fact you were at those times only permitted to observe patient care on intensive care settings in a supernumerary capacity.**

And that in light of the above your fitness to practise is impaired by reason of your Misconduct at charges 1 to 10, 12 – 19 and Lack of Competence at charge 11.

Schedule 2

a. **5th October 2018 – The Homerton Hospital, ITU**
b. **7th October 2018 The Homerton Hospital, ITU**
c. **13th January 2019 For TCS Agency caring for Patient A at home**
d. **15th January 2019 For TCS Agency caring for Patient A at home**
e. **16th January 2019 For TCS Agency caring for Patient A at home**
f. **5th February 2019 For TCS Agency caring for Patient A at home**
g. **6th February 2019 For TCS Agency caring for Patient A at home**
h. **27th August 2020- Princess Grace Hospital, ITU**
i. **28th August 2020- London Bridge Hospital, ITU**
j. **1st September 2020- Wellington Hospital, ITU North**
k. **4th September 2020- Wellington Hospital, ITU South**
l. **8th September 2020- Wellington Hospital, ITU North**
m. **8th September 2020- Wellington Hospital, ITU South**
n. **13th September 2020- Bupa Cromwell Hospital, ITU**
o. **17th September 2020-London Bridge Hospital, ITU**
p. **25th September 2020- Royal Brompton Hospital, AICU/ITU**
q. **27th September 2020-Chelsea and Westminster Hospital, ITU**
r. **30th September 2020 - St. John & St. Elizabeth's hospital , ITU/HDU**

The panel acknowledged that the addition of charges 18 and 19 at this stage of the proceedings could result in prejudice to your interests in this case. However, it would also enable you to address these allegations directly and for the panel to make specific findings on these issues. The panel noted that the proposed charges would appropriately reflect the evidence in this case and there is relevant information in the NMC Exhibit Bundle that may support these charges.

The panel further noted that there was advance notice given to you by Ms Butler of the general nature of the proposed charges that she would be applying to add to this case and that notice was given before the relevant witnesses were called to give evidence. While the addition of charge 19 is serious in this case as it involves an allegation of dishonesty, the panel bore in mind its overarching duty to protect the public and it was therefore satisfied that this duty outweighs any prejudice to your

interests in this regard. The panel therefore determined that it is in the interest of justice to allow these amendments.

The panel, of its own volition, further amended charge 18 by replacing the word ***'probationary'*** with the *word '**ICU**'* in order to provide clarity to the charge:

> *'having failed to achieve your **ICU** Step 1 competencies by July 2017'*

The panel, on its own volition, also amended charge 19 by replacing the word ***'qualified'*** with the word '***competent***', and also replaced the word *'**observe**'* with the words ***'be involved in'*** in order to provide clarity to the charge:

> *' Your actions at 18 were dishonest in that you sought to mislead the agency, hospital intensive care units and community settings employers at Schedule 2 that you were **competent** to look after intensive care patients when in fact you were at those times only permitted to **be involved in** patient care on intensive care settings in a supernumerary capacity'*

The panel was satisfied that no injustice would be caused to either party by these amendments.

Updated details of charge:

That you, a registered nurse

1. Whilst caring for Patient A on 5 and 6 February 2019:

    a) did not take all the hourly observations
    b) did not undertake the daily emergency equipment checks
    c) did not undertake auscultation every 2 hours
    d) on the 5 February 2019 at an unknown time between 1700 and 2000, changed the setting on the non-invasive positive pressure ventilation ('NIPPY') machine from EPAP 7 to 6

e) changed the ‘NIPPY’ EPAP setting to 6.0 contrary to the Care Plan and Ventilation Prescription of 06/11/2018.

f) on 5 February 2019 failed to maintain the appropriate IPAP pressures on 8 or more occasions contrary to the Care Plan and Ventilation Prescription of 06/11/2018

g) on 6 February 2019 failed to maintain the appropriate IPAP pressures on 11 or more occasions contrary to the Care Plan and Ventilation Prescription of 06/11/2018

h) on 5 February 2019 took only one blood pressure reading during the course of a 12 hour shift

2. On the 5 and 6 February 2019 did not complete Patient A’s records for:
   a. auscultation
   b. fluids
   c. blood pressure
   d. the rationale for changes to the NIPPY settings for both IPAP and EPAP
   e. daily emergency equipment checks
   f. nebulisers administered

3. On 5 February 2019 recorded an unprescribed ventilation pressure on the handover and observation chart in that you recorded 6.0 for EPAP

4. On 6 February 2019 failed to identify and/or act on Patient A
   a. not receiving sufficient ventilation in that you maintained his EPAP at 6.0 for the entire shift contrary to the Care Plan and Ventilation Prescription of 06/11/2018
   b. increased blood pressure of 114/98 at 1200hrs and 152/87 at 1600 hrs
   c. incorrect tidal volumes

5. On the 5 and 7 October 2018, worked shifts as a nurse for Homerton Hospital while in receipt of sick pay from Barts Health NHS Trust

6. Your actions at charge 5 were dishonest in that you represented to Barts Health NHS Trust, that you were entitled to receive sick pay when you knew you were not.

7. On 10 October 2018, emailed Colleague A, your line manager stating the enclosed time sheets were for shifts from ages ago that had not been paid.

8. Your actions at charge 7 were dishonest in that you sought to mislead Colleague A, to believe the timesheets were not for 5 and 7 October 2018.

9. On 30 May 2019 stated to Colleague B, you had not worked at Homerton Hospital on 5 and 7 October 2018, when in fact you had.

10. Your actions at charge 9, were dishonest in that you sought to deceive Colleague B, into believing you had not worked for Homerton Hospital on 5 and 7 October 2018.

11. That you, between 5 December 2016 and 29 June 2019 whilst employed as a Band 5 nurse at Barts Health NHS Trust in ICU failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse for Level 2 and 3 critical care patients in that you:

    a. Whilst subject to a probationary period between 5 December 2016 and 24 July 2017 failed to meet the following objectives:
        i. Documentation
        ii. Communication
        iii. Time management and organisation
        iv. Basic care
        v. Patient Assessment
        vi. Safe care of level 2 and level 3 Patients
        vii. Complete 125 essential skills in step 1 competencies
        viii. Complete all IV competencies

b. Whilst subject to an informal capability process period between 24 July 2017 and 12 January 2018 failed to meet the following objectives
    i. Follow unit guidelines, implementing policies and procedures correctly
    ii. Time management and organisation
    iii. Documentation (timing and accuracy)
    iv. Clear and effective communication

c. Whilst subject to a formal capability process between 12 January 2018 and 28 June 2019 failed to meet the following objectives:
    i. Follow unit guidelines, implementing policies and procedures correctly.
    ii. Time management and organisation
    iii. Documentation (timing and accuracy
    iv. Clear and effective communication
    v. Re-assessment of certain 0–6-month competencies of ventilation, setting up and care of transducers, pharmacology and drug administration and cardiovascular system

12. Between July 2019 and 6 March 2020 when applying and/or accepting the role of a Band 5 Staff Nurse at Royal Papworth Hospital failed to declare
    a. your employment at St Bartholomew's Hospital and/or
    b. being under a capability process whilst employed at St Bartholomew's Hospital and/or
    c. being issued with a final written warning for gross misconduct by St Bartholomew's Hospital and/or
    d. your referral to the NMC

13. Your conduct at charge 12 was dishonest in that you intended to mislead the Royal Papworth Hospital as to your
    a. previous employment with St Bartholomew's Hospital
    b. previous capability concerns

c. a final written warning
d. the NMC referral

14. Breached an Interim Conditions of practice order which was first imposed on 25 August 2020 by the Investigation Committee of the Nursing and Midwifery Council in that you:
    a. failed to disclose to Zentar Healthcare that you were subject to an interim conditions of practice order and/or provide them with the conditions.
    b. on 30 September 2020 worked for St John and St Elizabeth Hospital and failed to disclose that you were subject to an interim conditions of practice order and/or provide a copy of the conditions
    c. withheld your NMC PIN from St John and St Elizabeth Hospital induction sheet on 30 September 2020

15. Your actions set out at charge 14c above were dishonest in that you sought to mislead St John and St Elizabeth Hospital and/or undertake work without restriction.

16. On the 30 September 2020 worked an agency shift at St John and St Elizabeth Hospital and breached an interim conditions of practise order which was first imposed 25 August 2020 by the Investigating Committee of the Nursing and Midwifery Council in that you:
    a. breached condition 1, by not limiting your practice to St Thomas' Hospital
    b. breached condition 2, by working bank and/or agency shifts.
    c. breached condition 3, by working without supervision of another registered nurse that ought to have consisted of
        i. working on a supernumerary basis while undertaking and completing three months' probation as a new starter at St Thomas' Hospital
        ii. working at all times on the same shift, as but not always direct observed by, another registered nurse

iii. monthly meetings with your line manager to discuss your conduct and clinical competencies.

17. Worked 11 shifts at various hospitals as set out in schedule 1 in breach of the interim conditions of practice order imposed on 25 August 2020.

18. Between 1 October 2018 and 30 September 2020 you worked as an Agency Nurse on the Intensive Care Units and community settings at Schedule 2, knowing that you were at all times placed on Supernumerary Practise since August 30 2018 at St Bartholomew's Intensive Care Unit having failed to achieve your ICU Step 1 competencies by July 2017 and having failed to achieve your capability process objectives by June 2019.

19. Your actions at 18 were dishonest in that you sought to mislead the agency, hospital intensive care units and community settings employers at Schedule 2 that you were competent to look after intensive care patients when in fact you were at those times only permitted to be involved in patient care in intensive care settings in a supernumerary capacity.

And that in light of the above your fitness to practise is impaired by reason of your Misconduct at charges 1 to 10, 12 – 19 and Lack of Competence at charge 11.

Schedule 1

a. 27 August 2020 Princess Grace Hospital
b. 28 August 2020 London Bridge Hospital
c. 1 September 2020 Wellington Hospital
d. 4 September 2020 Wellington Hospital
e. 8 September 2020 Wellington Hospital ITU North
f. 8 September 2020 Wellington Hospital ITU South
g. 13 September 2020 Bupa Cromwell Hospital
h. 17 September 2020 London Bridge Hospital
i. 25 September 2020 Royal Brompton Hospital
j. 27 September 2020 Chelsea and Westminster Hospital
k. 30 September 2020 St John and St Elizabeth's Hospital

Schedule 2

a. 5th October 2018 – The Homerton Hospital, ITU
b. 7th October 2018 The Homerton Hospital, ITU
c. 12th January 2019 For TCS Agency caring for Patient A at home
d. 13th January 2019 For TCS Agency caring for Patient A at home
e. 15th January 2019 For TCS Agency caring for Patient A at home
f. 5th February 2019 For TCS Agency caring for Patient A at home
g. 6th February 2019 For TCS Agency caring for Patient A at home
h. 27th August 2020- Princess Grace Hospital, ITU
i. 28th August 2020- London Bridge Hospital, ITU
j. 1st September 2020- Wellington Hospital, ITU North
k. 4th September 2020- Wellington Hospital, ITU South
l. 8th September 2020- Wellington Hospital, ITU North
m. 8th September 2020- Wellington Hospital, ITU South
n. 13th September 2020- Bupa Cromwell Hospital, ITU
o. 17th September 2020-London Bridge Hospital, ITU
p. 25th September 2020- Royal Brompton Hospital, AICU/ITU
q. 27th September 2020-Chelsea and Westminster Hospital, ITU
r. 30th September 2020 - St. John & St. Elizabeth's hospital , ITU/HDU

Decision and reasons on application to withdraw admission to charge 7

Dr Akinoshun made an application to withdraw your admission to charge 7. He submitted that although he had informed the panel at the outset of the hearing that you had made an admission to charge 7, you actually intended to deny it. You had subsequently alerted him of this issue at the time he was reviewing the amended charges with you. Dr Akinoshun stated that you had asserted that you had instructed him to inform the panel of your denial of charge 7 prior to the hearing. He submitted that you did not alert him of the mistake due to [PRIVATE] you were facing at the time the charges were first read at the hearing.

Dr Akinoshun acknowledged that he had made an error in stating that you made admission to charge 7 and this may have arisen from miscommunication with you. He further accepted that this was his mistake and not yours. He submitted that it was your defence that when you sent the relevant email, you had intended to send four timesheets to AMC Professionals for the shifts you had worked with that agency and those timesheets were sent to Colleague A in error. He submitted that you would like to be afforded the opportunity to address the panel on the allegations in charge 7.

In conclusion, Dr Akinoshun invited the panel to grant your application in the interests of justice and fairness.

Ms Butler opposed your application to withdraw your admission to charge 7. She referred the panel to Section 38.5 of the Criminal Procedure Rules which provides that where a party wishes to vacate a guilty plea, such application must occur as soon as practicable after becoming aware of the grounds for doing so. Ms Butler submitted that although the Criminal Procedure Rules do not apply to these proceedings, its principles could be considered by the panel in making its decision on this application.

Ms Butler submitted that you have not discharged the burden of proof in this application and you had not made this application in an expeditious manner. She highlighted that the alleged mistake was made on the first day of the hearing but you waited until day 10 of these proceedings to make this application. She further highlighted that charge 7 was unambiguous and your admission was unequivocal.

Ms Butler referred the panel to your email to Colleague A dated 10 October 2018 and she submitted that there was sufficient documentary evidence to support charge 7. She asserted that you have not explained why it would be unjust for the panel to deny your application to withdraw your admission nor have you indicated, in clear terms, your defence in this case. She submitted that the defence you wish to present in relation to charge 7 is muddled and this may be a last gasp attempt by you to deflect the charge.

Ms Butler submitted that the NMC would be prejudiced if this application is granted given that it had been deprived of the opportunity to have questioned Colleague A with respect to charge 7 during her oral evidence.

In conclusion, Ms Butler invited the panel to refuse your application for the withdrawal of your admissions to charge 7.

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

The panel took into account that you are currently represented in these proceedings by Dr Akinoshun, and at the time the charges were first read at the outset of the hearing, he had informed the panel that you made admissions to a number of charges including charge 7. The panel considered the submission of Dr Akinoshun that at the time he was reviewing the amended charges with you, you immediately indicated to him that you actually denied charge 7. The panel noted that Dr Akinoshun had acknowledged that he had made an error in stating that you made admission to charge 7 and this may have arisen from miscommunication with you. He had further accepted that this was his mistake and not yours.

The panel accepted the submissions of Dr Akinoshun. The panel was of the view that the merits of the case and the fairness of the proceedings justified the application so that you are not made to suffer the consequences of the error of your representative. Although you had the opportunity to have corrected your representative on the first day of the hearing, the panel acknowledged that regulatory hearings are generally stressful and overwhelming for registrants and therefore you may have been stressed on that day. The panel was satisfied that there would be no injustice to the NMC if you are allowed to withdraw your admission as any unfairness could be mitigated by the recall of the NMC witnesses to give evidence on charge 7 and there is relevant information in the NMC Exhibit Bundle that may support charge 7.

The panel therefore granted your application.

Decision and reasons on no case to answer

At the close of the NMC's case, Ms Butler submitted, under Rule 24(8), that there was insufficient evidence to support charges 2b and 4c.

Dr Akinoshun did not oppose the submission of Ms Butler.

The panel heard and accepted the advice of the legal assessor. The legal assessor advised the panel that Rule 24(9) was engaged and it was open to the panel to find that there was no case to answer under 24(7) and 24(8).

The panel carefully considered the NMC's case and determined that there was insufficient evidence to support charges 2b and 4c. It therefore determined that there was no case to answer with respect to charges 2b and 4c.

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

Dr Akinoshun made an application that matters relating to [PRIVATE], which may be explored in the course of your evidence, be held in private. The application was made pursuant to Rule 19 of the Rules.

Ms Butler did not oppose the application.

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 accepted the advice of the legal assessor.

The panel determined to hold this hearing partly in private. It will go into private session as and when matters relating to [PRIVATE] are raised in order to protect their privacy.

Decision and reasons on application to withdraw admission to charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v) and 11a (vi)

At the close of the NMC's case, the amended charges as well as the new charges were put to you. Dr Akinoshun informed the panel that you had made some new admissions to the charges including charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v) and 11a (vi). However, in the course of your evidence, you clarified to the panel that you denied charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v) and 11a (vi).

Dr Akinoshun therefore made an application to withdraw your admissions to charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v) and 11a (vi). He submitted that although he had informed the panel at the close of the NMC's case, that you had made admissions to charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v) and 11a (vi), you actually intended to deny it. He stated that you had then clarified during your evidence that you deny those charges.

Dr Akinoshun acknowledged that he had made an error in stating that you made admissions to charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v) and 11a (vi) and this may have arisen from miscommunication with you. He further accepted that this was his mistake and not yours.

In conclusion, Dr Akinoshun invited the panel to grant your application in the interests of justice and fairness.

Ms Butler did not oppose your application to withdraw your admissions to charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v) and 11a (vi).

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

The panel took into account that you are currently represented in these proceedings by Dr Akinoshun, and at the time the amended and new charges were put to you, he had informed the panel that you made admissions to a number of charges including charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v) and 11a (vi). However, you had clarified that you denied those charges in the course of your evidence. The panel noted that Dr Akinoshun had acknowledged that he had made an error and this may have arisen from miscommunication with you. He had further accepted that this was his mistake and not yours.

The panel accepted the submissions of Dr Akinoshun. The panel was of the view that the merits of the case and the fairness of the proceedings justified the application so that you are not made to suffer the consequences of the error of your representative. The panel was satisfied that there would be no injustice to the NMC if you are allowed to withdraw your admissions as any unfairness could be mitigated by the recall of the NMC witnesses to give evidence on those charges and there is relevant information in the NMC Exhibit Bundle that may support them.

The panel therefore granted your application.

Decision and reasons on facts

Dr Akinoshun informed the panel that you made full admissions to charges 1d, 1e, 1h, 3, 12b, 14a, 14b, 16a, 16b, 16c (i), 16c (ii), 16c (iii) and 17.

The panel therefore finds charges 1d, 1e, 1h, 3, 12b, 14a, 14b, 16a, 16b, 16c (i), 16c (ii), 16c (iii) and 17 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 Butler and those made by Dr Akinoshun.

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 witnesses called on behalf of the NMC:

- Witness 1: Patient A's wife;

- Witness 2: Head of Nursing at Royal Papworth Hospital at the time of the incidents.
- Witness 3: Staff Nurse at St John & St Elizabeth Hospital, at the time of the incidents.
- Witness 4/Colleague B: Matron within the ACCU ('Adult Critical Care Unit') at Barts Health NHS Trust, at the time of the incidents.
- Witness 5/Colleague A: Line manager at St Bartholomew Hospital, at the time of the incidents.
- Witness 6: Clinical Nurse Manager at Thornbury Community Services, at the time of the incidents
- Witness 7: Clinical Lead at Thornbury Community Services, at the time of the incidents

The panel also heard evidence from you under oath.

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

In considering charges 1 – 4, the panel first reviewed the evidence of the NMC witnesses and your evidence in respect of the working environment and the conditions at Patient A's home.

The panel heard from the NMC witnesses with respect to the complex medical conditions of Patient A, the high level of 24 hour care he needed and the staffing levels required to address his condition. He required a ventilator and continuous monitoring of his condition to ensure his safety. Patient A was non-verbal and communicated with the use of eye movements and the assistance of technology. Patient A therefore required a registered nurse with specialist ITU competency and two healthcare assistants (HCA) at all times – you represented yourself as a specialist ITU nurse. Witness 1 who was previously Patient A's sole carer, was acknowledged to be very experienced in meeting his needs and was also at times involved in his care alongside the healthcare professionals.

You described the working conditions as *"intense*" and difficult due to the need to "*keep your eyes on Patient A at all times*". This meant that you were unable to take breaks, write up notes or read the care plan. You said Witness 1 did not allow you to have a break and expected that you engage with Patient A at all times, meaning that you could not do anything else and ended up working 14 hour shifts. You told the panel that you accepted that you may not have done all the observations as "*it was not humanly possible*" but you did the best that you could do. You also said that it was a challenging environment to work in due to the HCAs and Witness 1 not seeking your opinion or overriding your care decisions.

The panel noted from Patient A's care plan that there was an expectation that the three team members should share the responsibility for watching Patient A, rotating at 20 minute intervals, thereby allowing each of them to perform other duties and take breaks. However, the panel heard from you that, at no point did you read the care plan.

You told the panel that you felt underprepared, having expected to have *"a shadow shift*" before taking responsibility for Patient A. However, the panel heard from Witness 7 that all new nurses were given a full handover of care needs from herself

so that they would be familiarised before they arrived for the shift. They were also asked to arrive half an hour early for their first shift in order to read the care plan. Witness 7 further stated that, at the handover stage prior to the nurse being allocated to the case of a patient, if the nurse had concerns, they could decline the shift. It was not in dispute that the shifts of 5 and 6 February 2019 were not the first shifts that you had undertaken at Patient A's home, and therefore you were not unfamiliar with the requirements of Patient A's care, or the working environment.

With regard to the patient records for Patient A, the panel heard evidence from Witnesses 1 and 6 that the patient records were kept in a stapled bundle with all the forms required for each week (the weekly pack). The panel was provided with some but not all of the pages for the relevant week. The panel heard from Witnesses 1 and 6 that the weekly pack was readily available in the same room as Patient A.

In contrast, your evidence described the documentation in the room as chaotic, "*humongous"* with the weekly pack being muddled up. While Witnesses 1 and 6 accepted that there were some paper prompts stuck on the walls and on the NIPPY machine, they rejected your description of the room as chaotic and disorganised.

The panel noted that in Witness 6's Notes of Investigation Meeting with you dated 22 November 2019 and in your oral evidence, you stated that you were not aware of the required documents to be used to record your observations. You also stated that you recorded all the observations missing from the charts in the Record of events, contained in the weekly pack. However, in the course of your oral evidence, you stated that due to the busy nature of your shifts, you recorded some of your hourly observations on other documents, although exactly which ones you could not recall. You also stated that you may have recorded them on various pieces of paper, on occasions even including tissue papers. You accepted that at no point were these recordings transferred to the appropriate formal records and no alternative documents have been placed before the panel by either party in relation to any of these records. The panel was of the view that good record-keeping practice requires that all necessary records must be made in the appropriate records of the patient to ensure patient safety and continuity of care.

Witness 6 told the panel that she had conducted a review of Patient A's records in response to the complaints made by Witness 1. She confirmed that you had recorded some observations conducted on Patient A on the Record of events, but even including those, the evidence of Witness 6 was that the records were not fully completed. She also stated that it was unusual for the Record of events to be used in this way and to be completed prior to the observation records, especially where there were time constraints.

The panel considered the documentation provided to it and the evidence of Witness 7. Witness 7 told the panel that when she had cared for Patient A, she had found the workload and the documentation manageable. From the records, the panel had seen the night shift nurse had been able to complete the required observations and records despite the night shift being at least as busy as the day shift due to the nature of Patient A’s condition.

The panel preferred the consistent oral and documentary evidence of the NMC witnesses in respect of the working environment, the workload and the patient records set against your accounts, which the panel found to be both contradictory and improbable, in significant respects, given at the investigation meeting and in this hearing.

Charge 1a

1. Whilst caring for Patient A on 5 and 6 February 2019:
    a) did not take all the hourly observations

This charge is found proved

The panel had regard to the Patient A’s care plan which set out the required hourly observations that had to be conducted and recorded. The panel had sight of the day shift ventilator hourly record dated 5 February 2019 which should have been fully completed by you. It noted that there were no observations recorded by you until 10:00 as you stated in your evidence to the panel that you were late for work. It further noted that there were no observations recorded in the columns at 19:00 and

only two observations were recorded in the column at 18:00. It further noted that there were gaps in the columns for blood pressure and temperature respectively. The panel also had sight of the day shift ventilator hourly record dated 6 February 2019 on which it noted that there were also gaps in the columns for blood pressure and temperature respectively.

The panel took into consideration that you denied the allegation.

The panel rejected your explanations as unclear and inconsistent. It found your initial explanation that you did not know where you were supposed to write the results of your observations to be implausible given that you had used the day shift ventilator hourly record to record most of your observations during those shifts and therefore you must have known how to record this information in the appropriate place.

Your further explanation, given in your oral evidence, was that you were too busy to record your observations in the appropriate place, that you had conducted the observations but recorded the results on other pieces of paper due to the state of the patient records. The panel did not accept this explanation having found that the weekly pack was readily available and that you had appropriately recorded some of the required observations during your shift. The panel concluded that it was more likely than not that the missing records reflected observations that you had failed to undertake. The panel therefore concluded that you had not conducted all hourly observations as required, as there was no record of such observations.

In this regard, the panel was satisfied, on the balance of probabilities, that you did not take all the hourly observations whilst caring for Patient A on 5 and 6 February 2019. Accordingly, the panel found charge 1a proved.

Charges 1b and 2e

1. Whilst caring for Patient A on 5 and 6 February 2019:
   b) did not undertake the daily emergency equipment checks

2. On the 5 and 6 February 2019 did not complete Patient A’s records for:

e. Daily emergency equipment checks

These charges are found proved

The panel had regard to the Patient A's care plan which required that daily emergency equipment checks must be conducted on commencement of shift. The panel had sight of the record of Daily Checks. It noted that there was no record of emergency equipment checks conducted and signed by you during your day shifts on 5 and 6 February 2019.

The panel took into consideration that you denied the allegation. It noted that in Witness 6's Notes of Investigation Meeting with you dated 22 November 2019, you stated that you were not aware of the required documents to be used to record your daily emergency equipment checks. You stated that you conducted the emergency checks and you would not have started your shift without conducting them.

The panel accepted the clear and consistent evidence of Witnesses 1 and 6 that all the required records and charts were contained in the weekly pack which was given to you at your handovers, at the start of each shift. The panel noted that the nurse on the night shift had recorded all the required daily emergency equipment checks on the Record of Daily Checks. The panel was of the view that it was reasonable to infer that you had access to the appropriate form. The panel noted that in order to complete the emergency checks appropriately, you would have needed to use the list contained on the form. It found your explanation that you completed the daily checks without reference to the appropriate form to be implausible. The panel therefore rejected your explanations as unclear and inconsistent.

Where there was no record of such checks, the panel concluded that you had not conducted the daily emergency equipment checks as required.

In this regard, the panel was satisfied, on the balance of probabilities, that you did not undertake the daily emergency equipment checks nor complete Patient A's records, whilst caring for him on 5 and 6 February 2019. Accordingly, the panel found charges 1b and 2e proved.

Charges 1c and 2a

1. Whilst caring for Patient A on 5 and 6 February 2019:
   c) did not undertake auscultation every 2 hours

2. On the 5 and 6 February 2019 did not complete Patient A's records for:
   a. auscultation

These charges are found proved

The panel had regard to the Patient A's care plan which required that auscultation must be conducted at the start of each shift and hourly throughout the shift. However, the panel noted the evidence of Witness 6 that auscultation was required to be taken, as a minimum, every two hours on Patient A. The panel had sight of the Airway and Positioning Chart. It noted that there was no record of any auscultation conducted and signed by you during your day shifts on 5 and 6 February 2019.

The panel took into consideration that you denied the allegation. It noted that in Witness 6's Notes of Investigation Meeting with you dated 22 November 2019, you stated that you were not aware of the required documents to be used to record the auscultation. You also stated that you conducted auscultation more frequently than every two hours although you could not recall the exact frequency, but you conducted auscultation on Patient A anytime he desaturated. You further stated that you recorded such auscultation in the Record of events contained in the weekly pack and on cross-examination, you stated that you may have recorded them on a different auscultation chart.

The panel took into account that Witness 1 described you undertaking some auscultation albeit she said you had done it incorrectly. The panel also noted that the Thornbury complaint outcome letter stated that Patient A's chest was listened to five times during the day on 5 and 6 February 2019. Witness 6 further confirmed that you had recorded auscultation conducted on Patient A on the Record of events, but it was not conducted at least every two hours.

The panel found your explanation that you were not aware of the Airway and Positioning Chart to be implausible. The panel accepted the clear and consistent evidence of Witnesses 1 and 6 that all the required records and charts were contained in the weekly pack which was given to you at your handovers. The panel noted that the nurse on the night shift had recorded their auscultation checks on the Airway and Positioning Chart. The panel was of the view that it was reasonable to infer that you had access to the appropriate form but you failed to use it to record any auscultations.

The panel concluded that although there was evidence that you had conducted some auscultations on Patient A, it was more likely than not that you had not conducted auscultation every two hours.

In this regard, the panel was satisfied, on the balance of probabilities, that you did not undertake auscultation every two hours nor complete Patient A's records for auscultation, whilst caring for him on 5 and 6 February 2019. Accordingly, the panel found charges 1c and 2a proved.

Charges 1f and 1g

1. Whilst caring for Patient A on 5 and 6 February 2019:
    f) on 5 February 2019 failed to maintain the appropriate IPAP pressures on 8 or more occasions contrary to the Care Plan and Ventilation Prescription of 06/11/2018

    g) on 6 February 2019 failed to maintain the appropriate IPAP pressures on 11 or more occasions contrary to the Care Plan and Ventilation Prescription of 06/11/2018

These charges are found NOT proved

The panel took into account the submissions by Ms Butler that, on the day shift ventilator hourly record dated 6 February 2019, the IPAP settings from 8:00 to 17:00 were out of range, as they were recorded as '*28*', given that according to the Awake

and asleep ventilation settings instructions dated 6 November 2018, the IPAP settings for when Patient A was awake should have been '*27'*. Ms Butler highlighted that the Awake and asleep ventilation settings instructions indicated that the IPAP settings must be followed and could only be changed based on authorisation from the trained team at Glenfield Hospital. She also submitted that you failed to maintain the appropriate IPAP settings on 5 February 2019 as you exceeded the required settings on eight occasions with recordings of *'29'* and '*30'* at various times.

The panel took into consideration that you denied the allegation. You initially stated that you did not handle the IPAP settings as they were set automatically. However, in the course of your oral evidence, you accepted that the IPAP settings were not set automatically and would be set manually.

The panel had sight of the Awake and asleep ventilation settings instructions dated 6 November 2018. It noted that the recommended awake setting was 27 centimetres of water, and the asleep setting was 28 centimetres of water. The panel noted that the IPAP settings on the day shift ventilator hourly records for 5 and 6 February 2019 did not follow the Awake and asleep ventilation settings instructions on various occasions.

However, the panel noted that, in the IPAP settings on Patient A's care plan, completed on 13 December 2018, the recommended awake setting was 28 centimetres, and the asleep settings was 29 centimetres. In the panel's view, the IPAP settings on the day shift ventilator hourly records for 6 February 2019 aligns with the recommended IPAP settings in Patient A's care plan and was therefore in accordance with the most recent document and was therefore appropriate.

In any event, in respect of the IPAP settings on the Day shift ventilator hourly records for 5 February 2019, the panel noted that it was provided in both the Awake and asleep ventilation settings instructions and Patient A's care plan that the recommended IPAP settings could be increased to maximum of 32 centimetres when Patient A is experiencing difficulty and his vital signs had dropped. There was no evidence that the IPAP settings had ever exceeded this permitted maximum. The panel bore in mind that the burden of proof at the facts stage is on the NMC. The panel noted that it was not presented with any expert evidence by the NMC to demonstrate that your

adjustment of the IPAP settings was without clinical justification or was inappropriate on 5 February 2019.

In this regard, the panel was not satisfied that the NMC had discharged its burden of proof with respect to charges 1f and 1g. Accordingly, the panel found charges 1f and 1g not proved.

Charge 2c

2. On the 5 and 6 February 2019 did not complete Patient A's records for:
    c. Blood pressure

This charge is found proved

The panel had regard to the Patient A's care plan which required that blood pressure must be checked throughout the day and night. The panel had sight of the day shift ventilator hourly record dated 5 February 2019. It noted that there was only one record of the blood pressure checked, in the column at 11:00 and no other record was made for other hours of the day. The panel also had sight of the day shift ventilator hourly record dated 6 February 2019. It noted that there were four records of the blood pressure checked but there were no other records made for other hours of the day.

The panel took into consideration that you denied the allegation.

The panel rejected your explanations as unclear and inconsistent. It found your initial explanation that you did not know where you were supposed to write the results of the blood pressure readings to be implausible given that you had used the day shift ventilator hourly record to record some blood pressure readings during those shifts and therefore you must have known how to record this information in the appropriate place.

Your further explanation, given in your oral evidence, was that you were too busy to record some blood pressure readings in the appropriate place, that you had

conducted them but recorded the results on other pieces of paper due to the state of the patient records. The panel did not accept this explanation having found that the weekly pack was readily available and that you had recorded some blood readings during your shift.

In this regard, the panel was satisfied, on the balance of probabilities, that you did not complete Patient A's records for blood pressure on 5 and 6 February 2019. Accordingly, the panel found charge 2c proved.

Charge 2d

2. On the 5 and 6 February 2019 did not complete Patient A's records for:
    d. the rationale for changes to the NIPPY settings for both IPAP and EPAP

This charge is found proved

The panel took into account that Ms Butler highlighted that the Awake and asleep ventilation settings instructions dated 6 November 2018 indicated that the NIPPY settings for both EPAP and IPAP must be followed and could only be changed based on authorisation from the trained team at Glenfield Hospital and the rationale for such changes must be recorded.

The panel took into consideration that you admitted that you made changes to the NIPPY settings for both IPAP and EPAP. You stated that you made those changes based on the advice of Witness 7, the Clinical Lead at TCS. You further stated that you provided the reasons for the changes on the Shift handover form dated 5 February 2019.

The panel noted that Witness 7 denied in her oral evidence that she advised you to change the NIPPY settings for both IPAP and EPAP. She stated that she would always advise following the parameters within the care plan and would never advise working outside this. Witness 7 said the care plan was clear and comprehensive and included information about what to do in the event of an emergency. Further, Witness 7 pointed

out that the relevant information was written in red so that staff could see that it was important.

The panel had sight of the shift handover form dated 5 February 2019. It noted that you indicated in that form that the NIPPY settings were adjusted due to desaturations. However, there were no reasons provided on the shift handover form dated 6 February 2019 for the changes made to the NIPPY settings on that day.

Witnesses 6 and 7 also identified that given the review of the other observation parameters, the changes made were not clinically appropriate. Increasing rather than reducing the IPAP when a patient is desaturating would be the expected course of action to support their breathing. Further, Witness 6 stated that based on your responses to her questions during the investigation meeting, she was not satisfied that you had a good understanding of the NIPPY machine and the settings required.

The panel noted that good record-keeping practice requires that all necessary records must be made in the appropriate records of the patient to ensure patient safety and continuity of care. It accepted the evidence of Witness 6 that the rationale that you provided was inadequate given that changes were made to the NIPPY settings several times during your shifts.

Given that you failed to provide adequate rationale for the changes to the NIPPY settings on 5 February 2019 and there was no evidence of any record made on the rationale for the changes to the NIPPY settings on 6 February 2019, the panel found charge 2d proved on the balance of probabilities.

Charge 2f

2. On the 5 and 6 February 2019 did not complete Patient A's records for:
    f. Nebulisers administered

This charge is found proved

The panel had regard to Patient A's care plan which required that nebulisers should be regularly administered to Patient A and outlined circumstances when nebulisers should be given. Witnesses 1, 6, and 7 explained that Patient A was prone to getting mucous plugs and nebulisers were regularly required to loosen the secretions so that breathing was not compromised. The panel had sight of the day shift ventilator hourly records dated 5 and 6 February 2019 respectively. It noted that there were several gaps in the time columns, where it was not identified whether the nebuliser was given during that hour.

The panel took into consideration that you denied the allegation. It noted that in Witness 6's Notes of Investigation Meeting with you dated 22 November 2019, you stated that you were not aware of the required documents to be used to record your observations. You also stated that you recorded the nebulisers given on the Record of events contained in the weekly pack.

The panel rejected your explanation as unclear and inconsistent. It found your explanation to be implausible given that you used the day shift ventilator hourly record to record some of the nebuliser administration during those shifts. The panel noted that good record-keeping practice requires that all necessary records must be adequately completed in the appropriate records of the patient to ensure patient safety and continuity of care. In this case, the appropriate record was the Day shift ventilator hourly Record.

Witness 1 described you preparing and administering nebulisers on 5 February 2019 albeit she said you were doing it incorrectly. Those nebulisers were not recorded on the day shift ventilator hourly record. It was not challenged on your behalf that you administered nebulisers on 5 February 2019.

In this regard, the panel was satisfied, on the balance of probabilities, that you did not complete Patient A's records for nebulisers given on 5 and 6 February 2019. Accordingly, the panel found charge 2f proved.

Charge 4a

4. On 6 February 2019 failed to identify and/or act on Patient A
    a. not receiving sufficient ventilation in that you maintained his EPAP at 6.0 for the entire shift contrary to the Care Plan and Ventilation Prescription of 06/11/2018

This charge is found proved

The panel had sight of the Awake and asleep ventilation settings instructions dated 6 November 2018 as well as Patient A's care plan. It noted that the recommended EPAP awake and asleep setting in both documents was 7 centimetres of water. The panel noted that the EPAP settings on the Day shift ventilator hourly records for 6 February 2019 was 6 centimetres throughout the day which did not follow the Awake and asleep ventilation recommended EPAP settings.

The panel took into account that Witness 1 stated in her witness statement:

> *'During the afternoon I noticed Patient A's SATs we're unstable, and Patient A was requesting support. Patient A went on oxygen and we attempted mouth care at Patient A's request, which was unsuccessful. This is monitored by a 'Sats probe' and using a stethoscope. I made 'Kemi' aware of this and she listened to Patient A's chest. She informed me that it was ok quiet and not much difference and appeared the same however I was telling it didn't look right so 'Kemi' said she would give him something because I said. I asked if I could listen to Patient A's chest, I heard crackles and strides, Patient A's chest didn't sound right and I explained what I could hear*
>
> *'Throughout the afternoon I made 'Kemi' aware that Patient A's breathing didn't seem right. I made reference to this several times and 'Kemi' would have a look at the 'Nippy 3 plus' machine which monitors Patient A's breathing and provide me with a reading'*

The panel took into consideration that Witness 6 stated during her oral evidence that although Patient A's care plan had previously set the EPAP setting at 6 centimetres of water, the care plan was amended and the EPAP increased to 7 centimetres as a

result of his condition worsening and his increased need for ventilation support. Although the Specialist Doctor had stated in the Leicestershire Police Report that, generally, EPAP settings of 6 - 7 centimetres were appropriate, Witness 6, who had detailed knowledge of Patient A and his care plan, maintained that EPAP setting on 6 centimetres was not specifically appropriate for Patient A and therefore Patient A was not receiving sufficient ventilation on 6 February 2019.

The panel took into account that you denied the allegation and you stated that you were advised to change the EPAP setting to 6 centimetres on the advice of Witness 7. In your oral evidence, you stated that you did not believe that Patient A received insufficient ventilation as he was not unwell and was saturating well. This was inconsistent with your reasoning for calling Witness 7, the Clinical Lead. You stated that you called, requesting advice due to Patient A desaturating and being given too much oxygen by Witness 1 and a HCA against your advice.

The panel noted that Witness 7 denied in her oral evidence that she advised you to change the NIPPY settings for both IPAP and EPAP. She stated that she would always advise following the parameters within the care plan and would never advise working outside this. Witness 7 said the care plan was clear and comprehensive and included information about what to do in the event of an emergency. Further, Witness 7 pointed out that the relevant information was written in red so that staff could see that it was important.

The panel accepted the evidence of Witnesses 1, 6, and 7 as they were clear and consistent with each other. The panel concluded that even when Witness 1 drew your attention to the condition of Patient A, you had not identified that he was receiving insufficient ventilation support or that the EPAP setting was outside the recommendations in the Awake and asleep ventilation settings instructions dated 6 November 2018 as well as Patient A’s care plan. You also failed to act appropriately to ensure that Patient A was receiving sufficient ventilation. In this regard, the panel found charge 4a proved on the balance of probabilities.

Charge 4b

4. On 6 February 2019 failed to identify and/or act on Patient A
    b. Increased blood pressure of 114/98 at 1200hrs and 152/87 at 1600 hrs

This charge is found proved

The panel took into account Witness 1's Complaint email to TCS dated 18 March 2019 in which she indicated that on 6 February 2019, when Patient A's blood pressure was high, you failed to identify such concern, nor did you act on it.

The panel took into consideration that Witness 6 stated during her oral evidence that Patient A's blood pressure readings at 114/98 and 152/87 were very high and it was expected that you should have identified such concern and acted on it.

The panel had sight of the blood pressure readings recorded on the day shift ventilator hourly records for 6 February 2019, which showed blood pressure of 114/98 at 1200hrs and 152/87 at 16:00. The panel noted that during your oral evidence, when you were asked about your views on Patient A's blood pressure readings at 114/98 and 152/87, you did not understand how the blood pressure readings were high. You stated that you did not consider those blood pressure readings to be high because the first reading (114/98) was at a time when Patient A had used the commode and holding his head during this process would have raised his blood pressure. For the second reading (152/87), you said that this was *"incidental"*. You explained this by saying if you ran up the stairs, your blood pressure would go up. However, when asked if you had seen Patient A's baseline blood pressure so you know when to worry, you said you do not remember seeing it.

Having failed to identify the increased blood pressure readings, you accepted that you did not take any action in response. In fact, you told the panel that you had already given Patient A his medication for his blood pressure and therefore there was not anything else to do.

Based on the evidence before it, including the evidence of Witnesses 1 and 6 which were clear and consistent with each other, as well as your inability to identify those

readings as high during your oral evidence, the panel was satisfied, on the balance of probabilities, that on 6 February 2019, you failed to identify and act on Patient A's increased blood pressure of 114/98 at 12:00 and 152/87 at 1600. Accordingly, the panel found charge 4b proved.

Charge 5

5. On the 5 and 7 October 2018, worked shifts as a nurse for Homerton Hospital while in receipt of sick pay from Barts Health NHS Trust

This charge is found proved

The panel took account of the witness statement of Colleague A in which she stated:

> *'During the time that I was managing Adekemi's performance issues, I received an email from her which contained timesheets from bank shifts worked at the Homerton whilst she was on sickness leave at Barts Health NHS Trust. I believe these had been sent in error after I had requested that she email me a copy of her current sickness certificate. From memory, the email I received only contained the two timesheets, there was nothing written in the email - just the attachments. Not long after receiving the timesheets, I received another email from Adekemi stating she had sent the timesheets in error and that they were for shifts that were not paid from a while ago.'*

This was confirmed by Colleague B in both his oral and documentary evidence that you had sent to Colleague A two time sheets consisting of a shift for 07:30 to 20:00 on 5 October 2018 and for a further shift for 07:30 to 20:00 on 7 October 2018.

The panel took into consideration that you admitted that you had worked two shifts on 5 and 7 October 2018 as a nurse for Homerton Hospital. However, you denied that you were in receipt of sick pay from Barts during that period. You stated that you believed that you sent a letter of resignation in lieu of notice in September 2018 and therefore, you could not have been paid given that you had not sent a sick note covering 4 – 7 October 2018. However, you accepted in your oral evidence that the

resignation letter was not sent as you had asked your son to post it but he had forgotten.

The panel had sight of the two emails you had sent to Colleague A dated 10 October 2018 in which you had attached the bank timesheets for shifts worked in Homerton Hospital and where you had told Colleague A that they had been sent in error as your sickness had been extended. The panel had regard to Barts Disciplinary investigation report dated 14 August 2019. It noted that Colleague A indicated in that report that there was no evidence that you had sent your resignation letter to Barts in September 2018. The investigation report further indicated that although there was no sickness note to cover 4 – 7 October 2018, the information recorded in the health roster at Barts showed that you were under sick leave during that period. The investigation report identified that you provided sick notes for immediately before this period and immediately after this period with no evidence that you had returned to work, therefore, you were paid by Barts for the whole period of sickness.

The panel also had regard to the counter fraud report which confirmed that you were in receipt of sick pay for 5 and 7 October 2018. It further recommended that Barts should either obtain sick notes for the period of 4 – 7 October 2018 to support the entry on the heath roster or your manager should complete a health roster correction form to notify Barts payroll department that an over payment had been made for the period of 4 – 7 October 2018.

The panel accepted the accounts of Colleagues A and B as they were clear and consistent in both their oral and documentary evidence. They were also consistent with the Barts Disciplinary investigation report and the counter fraud report.

Based on the evidence before it, the panel was satisfied, on the balance of probabilities, that on 5 and 7 October 2018, you had worked shifts as a nurse for Homerton Hospital while in receipt of sick pay from Barts Health NHS Trust. Accordingly, the panel found charge 5 proved.

Charge 6

6. Your actions at charge 5 were dishonest in that you represented to Barts Health NHS Trust, that you were entitled to receive sick pay when you knew you were not.

This charge is found proved

Having found charge 5 proved, the panel went on to consider whether your conduct in charge 5 was dishonest in that you represented to Barts Health NHS Trust, that you were entitled to receive sick pay when you knew you were not. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the registrant's actual state of knowledge or belief as to the facts; and
- was that conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to charge 5, the panel took into account that, in response to Colleague A's request on 10 October 2018 for your sick notes, you sent two bank timesheets for shifts worked on 5 and 7 October 2018 in Homerton Hospital. You further sent an email to Colleague A on the same day stating:

> *'Hello again, I have just noticed that I have sent you a timesheet in error, did you receive it? For your information (This is private) Its for a shift that wasn't paid ages ago, I was advised to send it in, with that date, I have been paying for my medicines, I have hospital in woolwich due to the discharge note, that's why my sickness is been extended, I owe you this explanation, and I haven't been seeing clearly.'*

The panel noted that you sent a new sick note to Colleague A dated 6 October 2018. The panel was of the view that based on your two emails to Colleague A dated 10 October 2018 and your subsequent action in sending a new sick note, you were representing yourself as still being under sick leave within the period of 5 and 7

October 2018 and therefore entitled to sick pay. The panel noted that there was no evidence before it that you had sent a resignation notice to Barts in September 2018 nor had you mentioned your resignation in any other correspondence. It further noted that you subsequently admitted that you had worked shifts as a nurse for Homerton Hospital on 5 and 7 October 2018.

Based on the evidence before it, the panel was satisfied, on the balance of probabilities, that you knew that you were not entitled to sick leave and sick pay on 5 and 7 October 2018, when you represented to Barts that your sickness continued.

In applying the second limb of the test to this case, the panel was satisfied that your conduct in representing to Barts, that you were entitled to receive sick pay, when you were working elsewhere and you knew you were not, would be considered dishonest by ordinary decent people.

Accordingly, on the balance of probabilities, the panel determined that your conduct in charge 5 was dishonest and it therefore found charge 6 proved.

Charge 7

7. On 10 October 2018, emailed Colleague A, your line manager stating the enclosed time sheets were for shifts from ages ago that had not been paid.

This charge is found proved

The panel took into account that, in response to Colleague A's request on 10 October 2018 for your sick notes, you sent two signed and countersigned bank timesheets for shifts worked on 5 and 7 October 2018 in Homerton Hospital. You further sent an email to Colleague A on the same day stating:

> *'Hello again, I have just noticed that I have sent you a timesheet in error, did you receive it? For your information (This is private) Its for a shift that wasn't paid ages ago, I was advised to send it in, with that date, I have been paying*

for my medicines, I have hospital in woolwich due to the discharge note, that's why my sickness is been extended, I owe you this explanation, and I haven't been seeing clearly.'

The panel took into consideration that you denied the allegation. You stated that you sent the bank timesheets in error to Colleague A, as on that day, you were sending several emails to your agency and Colleague A, and you got confused.

The panel rejected your explanation as it found it implausible that the email was not intended for Colleague A as you sought to clarify in that email why you had sent the time sheets to her. Based on the evidence before it, the panel was satisfied, on the balance of probabilities, that on 10 October 2018, you emailed Colleague A, your line manager, stating the enclosed time sheets were for shifts from ages ago that had not been paid. Accordingly, the panel found charge 7 proved.

Charge 8

8. Your actions at charge 7 were dishonest in that you sought to mislead Colleague A, to believe the timesheets were not for 5 and 7 October 2018.

This charge is found proved

Having found charge 7 proved, the panel went on to consider whether your conduct in charge 7 was dishonest in that you sought to mislead Colleague A, to believe the timesheets were not for 5 and 7 October 2018. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance DMA-8. It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited.*

In applying the first limb of the test to charge 7, the panel was of the view that once you sent the email containing the timesheets to Colleague A in error, you tried to conceal the fact that you had worked bank shifts on 5 and 7 October 2018 for Homerton Hospital whilst on sick leave. You did this by sending another email to Colleague A indicating that the time sheets were for shifts ages ago that were not paid and that you were advised by Colleague D to send them with those dates. In the

panel's judgement, by the express words of your email, you tried to mislead Colleague A as you knew that the timesheets were not for any shift worked ages ago but for shifts worked on 5 and 7 October 2018 for Homerton Hospital.

In applying the second limb of the test to this case, the panel was satisfied that your conduct in charge 7 would be considered dishonest by ordinary decent people.

Accordingly, on the balance of probabilities, the panel determined that your conduct in charge 7 was dishonest and it therefore found charge 8 proved.

Charge 9

9. On 30 May 2019 stated to Colleague B, you had not worked at Homerton Hospital on 5 and 7 October 2018, when in fact you had.

This charge is found proved

The panel took into account Colleague B's Notes of investigative meeting with you dated 8 August 2019 in which it was highlighted by Colleague B that you had inaccurately told him during an informal meeting on 30 May 2019 that you had not worked at Homerton Hospital on 5 and 7 October 2018. The panel noted that, in response, you stated that you were so nervous during the informal meeting that you could not provide accurate information, and this was the reason that you did not realise the misinformation you had given during that informal meeting. The panel noted that this issue was highlighted in Barts Disciplinary investigation report dated 14 August 2019.

The panel had sight of the email from Colleague B inviting you for an informal meeting scheduled on 30 May 2019. It also had sight of the email from Colleague B dated 30 May 2019 which contained a summary of the informal meeting he held with you.

The panel took into consideration that you denied the allegation. You stated during your oral evidence that you were never asked about your bank shifts at Homerton Hospital on 5 and 7 October 2018 or whether you had worked those shifts. You stated

that you were not given the opportunity by Barts to either admit or deny the allegation. You asserted that if you had been asked about those shifts by Colleague B, you would not have denied it.

The panel rejected your explanation as it was inconsistent with the contemporaneous documentary evidence before it. The panel noted that Colleague B was clear and consistent in his oral and documentary evidence that you had told him on 30 May 2019 that you did not work at Homerton Hospital on 5 and 7 October 2018. The panel therefore accepted Colleague B's account of the incident.

Based on the evidence before it, the panel was satisfied, on the balance of probabilities, that on 30 May 2019, you stated to Colleague B, you had not worked at Homerton Hospital on 5 and 7 October 2018, when in fact you had. Accordingly, the panel found charge 9 proved.

Charge 10

10. Your actions at charge 9, were dishonest in that you sought to deceive Colleague B, into believing you had not worked for Homerton Hospital on 5 and 7 October 2018.

This charge is found proved

Having found charge 9 proved, the panel went on to consider whether your conduct in charge 9 was dishonest in that you sought to deceive Colleague B, into believing you had not worked for Homerton Hospital on 5 and 7 October 2018. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance DMA-8. It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited.*

In applying the first limb of the test to charge 9, the panel bore in mind its earlier finding that it rejected your explanation that you were never asked about your bank shifts at Homerton Hospital on 5 and 7 October 2018 nor given the opportunity to either deny or admit it. The panel was of the view that your explanation was inconsistent with the

contemporaneous documentary evidence before it that showed that you were asked about your bank shifts at Homerton Hospital, during the informal meeting with Colleague B on 30 May 2019 and during the investigative meeting dated 8 August 2019. The panel noted that it was recorded in Colleague B's Notes of investigative meeting with you dated 8 August 2019 that you stated that you were so nervous in the informal meeting that you gave inaccurate information to Colleague B.

The panel was of the view that your actions demonstrated that it was more likely than not that you knew you had worked for Homerton Hospital on 5 and 7 October 2018 but you sought to deceive Colleague B into believing that you had not.

In applying the second limb of the test to this case, the panel was satisfied that your conduct in charge 9 would be considered dishonest by ordinary decent people.

Accordingly, on the balance of probabilities, the panel determined that your conduct in charge 9 was dishonest and it therefore found charge 10 proved.

Charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v), 11a (vi), 11a (vii), and 11a (viii)

11. That you, between 5 December 2016 and 29 June 2019 whilst employed as a Band 5 nurse at Barts Health NHS Trust in ICU failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse for Level 2 and 3 critical care patients in that you:

    a. Whilst subject to a probationary period between 5 December 2016 and 24 July 2017 failed to meet the following objectives:
        i. Documentation
        ii. Communication
        iii. Time management and organisation
        iv. Basic care
        v. Patient Assessment
        vi. Safe care of level 2 and level 3 Patients
        vii. Complete 125 essential skills in step 1 competencies

viii. Complete all IV competencies

These charges are found proved

The panel took into account that, in your oral evidence, you said that the six weeks of critical care training you were told you would receive was not provided and you had to take matters into your own hands by attending a respiratory course at Kings College and a ventilator course somewhere else. Despite being known for asking a lot of questions, you were treated differently from other staff nurses, who you said, were secretly offered additional support. Instead, you were told to read books. You stated that you had worked at various ICUs within Barts and there were no issues raised about your communication, time management or anything else. You felt that in relation to basic care, patient assessment, and safe care of level 2 and level 3 patients, you had the transferrable skills already from where you had worked before.

The panel considered the contextual allegations made by you that you were a victim of being '*ganged up upon'* by your supervisors at Barts, you were not provided adequate support and training, and you worked within a hostile and toxic environment. The panel noted that your allegations of being '*ganged up upon'* and working within a toxic environment led to an employee grievance meeting at Barts on 25 April 2019, which you attended at which your grievances were not upheld.

The panel considered your allegation of being '*ganged up upon'* by your supervisors at Barts. It took into account that various supervisors (between 10 to 12 nurses) provided documented feedback on your performance between 2017 and 2018 during your probationary and informal capability process. It had sight of the various feedback notes made by the supervisors. The panel noted that each of these supervisors provided detailed and consistent feedback with a recurring theme of your alleged failings on various dates, and their feedback was supported by various documentary evidence including action plans, appraisal and capability meetings. Although, you alleged that none of the feedback emails were sent to you, the panel noted that you accepted during your oral evidence that you had received oral feedback from most of your supervisors at the time of your supervision. Furthermore, Colleague A stated during her oral evidence that you were informed of your

supervisors' feedback during your various capability meetings. The panel accepted Colleague A's evidence in respect of this concern.

The panel determined that, given the consistency of the feedback from a wide range of sources based on your practice observed between 2017 and 2018, and which were supported by a wide range of documentary evidence, it did not accept your allegation of being ganged up upon by your supervisors.

The panel also considered your allegation that you were not provided adequate support and training at Barts. It took into account that when you were allegedly unable to meet certain objectives at the end of your probationary period, your probation was extended. You were further placed under an informal capability process and a formal capability process, informal and formal performance action plans and appraisals. The panel noted that these processes were put in place by Barts to support your training as a registered nurse. This was supported by the oral evidence of Colleagues A and B, as well as documentary evidence before the panel. The panel also noted that you were provided at different times with compassionate and sick leave when requested by you. In this regard, the panel was satisfied that you were provided with sufficient support and training at Barts.

The panel considered whether you were working under a hostile and toxic environment at Barts. It considered the tone of the feedback, other documentary evidence, as well as the oral evidence of the witnesses who worked with you. It further noted that these steps taken by Barts to provide you with additional periods of supernumerary practice and support from senior members of staff demonstrated their commitment to your development as an ICU nurse. Based on the evidence before it, the panel determined that the working environment at Barts was supportive.

The panel next considered the disputed charges. It noted that you asserted that you were assessed and considered proficient with your competencies. You stated that you had completed the Critical care competency framework Barts heart centre – Band 5 staff nurse 0-6 month competencies (book one) and had been given book two, which would not have occurred if you had not completed the step one essential

competencies. The panel did not have sight of the completed book as you said it was in your possession but in your *"book dump".*

The panel took account of the Record of Review and Monitoring Meetings with Line Manager. The panel noted that the document showed that you had six probation review meetings with your line manager between 14 December 2016 and 14 June 2017, and it further indicated that you failed to meet the objectives as contained within charges 11a (i) – (viii). The panel took into account that this document was supported by the Learning and Development Action Plan dated 7 April 2017 which outlined the objectives you were expected to achieve. The panel also had sight of the letter from Barts dated 16 June 2017 inviting you to a formal probationary review meeting scheduled on 24 July 2017 in order to discuss your failure to achieve the set objectives. The panel further took into account that Colleague A confirmed in both her witness statement and oral evidence that you failed to achieve those set objectives whilst subject to a probationary period between 5 December 2016 and 24 July 2017.

Given the clear documentary evidence before it, the panel rejected your account. Based on the evidence before it, the panel found charges 11a (i), 11a (ii), 11a (iii), 11a (iv), 11a (v), 11a (vi), 11a (vii), and 11a (viii) proved on balance of probabilities.

Charges 11b (i), 11b (ii), 11b (iii), and 11b (iv)

11. That you, between 5 December 2016 and 29 June 2019 whilst employed as a Band 5 nurse at Barts Health NHS Trust in ICU failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse for Level 2 and 3 critical care patients in that you:

    b. Whilst subject to an informal capability process period between 24 July 2017 and 12 January 2018 failed to meet the following objectives
        i. Follow unit guidelines, implementing policies and procedures correctly

ii. Time management and organisation
iii. Documentation (timing and accuracy)
iv. Clear and effective communication

These charges are found proved

The panel bore in mind its earlier findings that you were not a victim of being ganged up upon by your supervisors at Barts, that you were provided with sufficient support and training at Barts, and the working environment was supportive.

In your oral evidence, you stated that you were a competent nurse. You explained that you had worked at Lewisham Hospital for eleven to twelve years in cardiac medicine and had done bank and agency shifts elsewhere without issues. You accepted there were problems during your first six-month probation but things improved, and you completed all that was expected of you after your two-week extension.

The panel considered the email from Colleague A to Barts Human Resources Advisor dated 8 September 2017. The panel took into account that due to your failure to meet the set objectives during your probationary period and that the probation period had lapsed, a decision was made by Barts to place you under the Trust capability process. The panel noted that you were first placed in an informal capability process which involved informal weekly 1 to 1 meetings with your line managers or mentors, regular feedback from your supervisors and performance action plans.

The panel had sight of the numerous feedback reports from your supervisors. It noted that each of these supervisors provided detailed and consistent feedback with a recurring theme of your alleged failings on various dates. The feedback was consistent that you were unable to provide accurate documentation and there were concerns about poor record-keeping. It indicated that you demonstrated a poor standard of basic nursing care and did not follow unit policies and procedures. It was further reported that you were unable to prioritise and organise your workload and struggled with effective time management and communication.

The panel noted that you were placed under a performance action plan on 26 October 2017 to address those concerns. The panel had sight of the record of the Capability Management Weekly 1 to 1 meeting between you and Colleague A on 30 November 2017. The document showed that you failed to achieve the objectives of the performance action plan. The panel further had sight of the record of the informal weekly 1 to 1 meeting between you and Colleague A on 12 January 2018 which confirmed that you failed to meet the objectives as contained within charges 11b (i) – (iv) at the conclusion of your informal capability process.

Given the clear documentary evidence before it, the panel rejected your account. Based on the evidence before it, the panel found charges 11b (i), 11b (ii), 11b (iii), and 11b (iv) proved on balance of probabilities.

Charges 11c (i), 11c (ii), 11c (iii), 11c (iv), and 11c (v)

11. That you, between 5 December 2016 and 29 June 2019 whilst employed as a Band 5 nurse at Barts Health NHS Trust in ICU failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse for Level 2 and 3 critical care patients in that you:

    c. Whilst subject to a formal capability process between 12 January 2018 and 28 June 2019 failed to meet the following objectives:
        i. Follow unit guidelines, implementing policies and procedures correctly
        ii. Time management and organisation
        iii. Documentation (timing and accuracy)
        iv. Clear and effective communication
        v. Re-assessment of certain 0–6-month competencies of ventilation, setting up and care of transducers, pharmacology and drug administration and cardiovascular system

These charges are found proved

The panel bore in mind its earlier findings that you were not a victim of being ganged up upon by your supervisors at Barts, that you were provided with sufficient support and training at Barts, and the working environment was supportive.

In your oral evidence, you stated that you were a competent nurse. You stated that you first saw the performance action plan on 26 October 2017 and did not know who formulated it as it was not part of the competency booklet. You said you were unsure how some objectives were tested as you were not assessed or tested. You gave an example that you used transducers up to four times a day, yet you were told that you had not achieved competency. You denied that there were any incidents as a result of your clinical practice therefore you did not understand why you were put on supernumerary practice and said to have not achieved expectations.

The panel had sight of the record of the informal weekly 1 to 1 meeting between you and Colleague A on 12 January 2018, which confirmed that you failed to meet the set objectives at the conclusion of your informal capability process and that the next step was a formal capability process.

The panel took account of the letter dated 4 February 2018 which contained the outcome of the first formal stage capability meeting held on 1 February 2018. The panel noted that a new set of objectives, as contained in charges 11c (i) –(v), were set out in that meeting and a new performance action plan dated 1 February 2018 was put in place. You were also required to continue to have weekly 1 to 1 meeting with your line manager or mentor, there should be a buddy system under which you would be supervised with regular feedback, and that you would work with a member of the education team.

The panel had regard to the Performance (Capability) Management Case for Final (Formal) Stage Hearing – Summary of Meetings and Clinical Feedback. The panel noted that the document stated:

> *'Since the formal stage capability meeting, we continued to receive concerning feedback from our colleagues regarding not only Adekemi's clinical performance but also her professional behaviour.'*

The panel took into consideration that you held several weekly 1 to 1 meetings and appraisals with your line managers and mentors. Furthermore, your performance action plan was reviewed and recommenced on 16 July 2018. The panel noted that an End of Formal Stage Capability review meeting was held on 4 September 2018 with you, your line managers and the Matron, where it was decided that you had not achieved the objectives set in your performance action plan and the next step was to proceed to the Final Formal Stage of the Capability Management Pathway which included a Final Stage Hearing.

The panel further took into account that Colleague A confirmed in both her witness statement and oral evidence that you failed to achieve those set objectives whilst subject to a formal capability process between 12 January 2018 and 28 June 2019. In her witness statement, Colleague A stated:

> *'Based on all the evidence and feedback gathered, I felt that ACCU was not the appropriate clinical area for Adekemi to be practicing. Despite there being some slight improvement seen in some areas at times, Adekemi failed to meet the competency level for a Staff Nurse at that stage in their development within the Critical Care environment. Adekemi did not have the level of knowledge, competence and skills to safely care for Level 2 and Level 3 patients. Aspects of her clinical practice and professional behaviour became unsafe to the point that patient safety was compromised.'*

Given the clear documentary evidence before it, the panel rejected your account. Based on the evidence before it, the panel found charges 11c (i), 11c (ii), 11c (iii), 11c (iv), and 11c (v) proved on balance of probabilities.

Charge 12a

12. Between July 2019 and 6 March 2020 when applying and/or accepting the role of a Band 5 Staff Nurse at Royal Papworth Hospital failed to declare
    a. your employment at St Bartholomew's Hospital and/or

This charge is found proved

The panel took into account that Witness 2 stated in her witness statement that:

> *'Nurse Adefidiya had not disclosed to Royal Papworth Hospital on her application that she had been previously employed by Barts Hospital...'*

The panel took into consideration that a fact-finding meeting was conducted on 11 March 2020 which led to a formal investigatory interview on 24 March 2020. In the investigatory interview, it was reported that you confirmed that you were employed by Barts despite this information being absent from your job application to Papworth. It was further reported that you stated that you did not declare your past employment in Barts because the application submitted to Papworth was the one that you had used to apply to Barts initially and you had not updated it.

The panel noted that, as a registered nurse, there was a duty to make a full disclosure and a duty of candour in respect of relevant matters. Your full employment history was clearly relevant to your job application and your subsequent acceptance of the nursing role at Papworth.

The panel had sight of your Papworth job application form and noted that you had not included your employment at Barts as part of your employment history.

The panel took into account that you denied the allegation in these proceedings. In your oral evidence, you stated that you were looking for a ventilation course online and came across the Papworth advert and took the opportunity to attend the recruitment day they had on offer. You said you had the same curriculum vitae (CV) saved on NHS jobs that you had used to apply to Barts and proceeded to forward it to Papworth without updating it. This meant that your employment with Barts was not reflected in the application.

However, the panel noted that when shown, during your cross-examination, evidence that you had updated some elements of the application at the time you completed it, you then stated that your failure to declare to Papworth was as a result of your carelessness. You further stated that it might have been a technical issue that prevented you from making the necessary declarations to Papworth. The panel

further noted that you had stated that you had used a manager from Barts as a reference. However, during your cross-examination, you were shown that this was not the case.

The panel further had sight of the interview notes dated 13 July 2019 and noted that it was not plausible that if you had mentioned your employment at Barts, it would not have been recorded by the interviewers and therefore it found that you did not mention your employment at Barts despite the fact that you were still employed in Barts at that time.

There was no record of you informing Papworth of your employment at Barts when you accepted your role there. The referral from Papworth was clear that they only became aware of your employment at Barts when they received the NMC interim order decision dated 6 March 2020.

Based on the evidence before it, the panel was satisfied, on the balance of probabilities, that you failed to declare your employment at Barts to Papworth when applying and/or accepting the role of a Band 5 Staff Nurse between July 2019 and 6 March 2020. Accordingly, the panel found charge 12a proved.

Charge 12c

12. Between July 2019 and 6 March 2020 when applying and/or accepting the role of a Band 5 Staff Nurse at Royal Papworth Hospital failed to declare
    c. being issued with a final written warning for gross misconduct by St Bartholomew's Hospital and/or

This charge is found proved

The panel took into account that in the NMC interim order decision letter dated 26 August 2020, it was reported that, at Barts disciplinary hearing on 23 October 2019, you were given a final written warning due to the gross misconduct relating to working elsewhere whilst off sick.

The panel was of the view that you ought to have known about such final written warning issued by Barts as it was reported in the NMC interim order decision letter that you appealed the decision of the disciplinary hearing, but it was upheld by Barts Director of Nursing on 20 December 2019. The panel further noted that you did not declare such final written warning to Papworth when you commenced your employment on 9 March 2020.

Based on the evidence before it, the panel was satisfied, on the balance of probabilities, that you failed to declare that you were issued with a final written warning for gross misconduct by Barts when accepting the role of a Band 5 Staff Nurse between July 2019 and 6 March 2020. Accordingly, the panel found charge 12c proved.

Charge 12d

12. Between July 2019 and 6 March 2020 when applying and/or accepting the role of a Band 5 Staff Nurse at Royal Papworth Hospital failed to declare
    d. your referral to the NMC

This charge is found proved

The panel took into account that Witness 2 stated in her witness statement that:

> *'At around 5pm on Friday 6 March 2020, Nurse Adefidiya made Royal Papworth Hospital aware that she had been made subject to an Interim Conditions of Practice Order by the NMC. It was at this point that Royal Papworth Hospital became aware that this was as a result of a referral made to the NMC by St Bartholomew's Hospital ("Barts") who had been her previous employer...'*

The panel took into consideration that a fact-finding meeting was conducted on 11 March 2020 which led to a formal investigatory interview on 24 March 2020. In the investigatory interview, it was reported that you denied knowing about the NMC referral as you had already left Barts. It was further reported that you stated that you

first became aware of the NMC referral on 27 February 2020 when you returned from abroad and discovered that you were to attend an NMC hearing on 6 March 2020. You accepted that you should have told Papworth about the NMC referral.

The panel took into account that although you denied the allegation in these proceedings, you maintained the same position you made during Papworth formal investigatory interview, during your oral evidence.

The panel took into consideration that the first referral about your nursing practice to the NMC was made by Witness 1 on 15 February 2019. It noted that the NMC sent a Notice of referral via post to your registered address on 4 March 2019. The panel further noted that there were several unsuccessful attempts by the NMC to contact you via telephone on 28 February 2019 and 17 July 2019. There were further reminder emails from the NMC to you on 30 September 2019, 10 October 2019 and 27 January 2020. You only responded to the NMC on 28 January 2020. The NMC further contacted via email on 13 February 2020 informing you about another referral, to which you replied in another email dated 21 February 2020.

The panel had sight of your Papworth job application form and noted that you did not declare your referral to the NMC. The panel further had sight of the interview notes dated 13 July 2019 and noted that you did not declare your referral to the NMC during your interview. The panel further noted that you did not declare your referral to Papworth until the end of the working day on Friday 6 March 2020 when you were due to commence your employment on Monday 9 March 2020.

Based on the evidence before it, the panel was satisfied, on the balance of probabilities, that you failed to declare your NMC referral to Papworth when applying and/or accepting the role of a Band 5 Staff Nurse between July 2019 and 6 March 2020. Accordingly, the panel found charge 12d proved.

Charges 13a, 13b, 13c, and 13d

13. Your conduct at charge 12 was dishonest in that you intended to mislead the Royal Papworth Hospital as to your

a. previous employment with St Bartholomew's Hospital
b. previous capability concerns
c. a final written warning
d. the NMC referral

These charges are found proved

Having found charge 12 proved, the panel went on to consider whether your conduct in charge 12 was dishonest in that you intended to mislead Papworth. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance DMA-8. It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited.*

In applying the first limb of the test to charge 12, the panel considered your explanations. It noted that you stated that the application submitted to Papworth was the one that you had used to apply to Barts initially and you had not corrected it. However, the panel noted that during your cross-examination when shown evidence that you had updated the application at the time you filled it, you then stated that your failure to declare to Papworth was as a result of your carelessness. You further stated that it might have been a technical issue that prevented you from making the necessary declarations to Papworth. The panel further noted that you had stated that you had used a manager from Barts as a reference. However, during your cross-examination, you were shown that there was no manager from Barts used as a reference in your Papworth application form.

The panel rejected your explanations as they were inconsistent and implausible. The panel noted that you also had various opportunities to make those declarations during your interview and prior to Friday 6 March 2020 just before you were due to commence your employment at Papworth, but you did not. The panel was of the view that given your failure to make those declarations on multiple occasions, it was reasonable to infer that you knew that you were expected to make those declarations, but you intended to mislead Papworth about them in order to gain employment there.

In applying the second limb of the test to this case, the panel was satisfied that your conduct in charge 12 would be considered dishonest by ordinary decent people.

Accordingly, on the balance of probabilities, the panel determined that your conduct in charge 12 was dishonest and it therefore found charge 13 proved.

Charge 14c

14. Breached an Interim Conditions of practice order which was first imposed on 25 August 2020 by the Investigation Committee of the Nursing and Midwifery Council in that you:
    c. withheld your NMC PIN from St John and St Elizabeth Hospital induction sheet on 30 September 2020

This charge is found NOT proved

The panel took account of the witness statement of Witness 3 in which she stated:

> *'When the registrant commenced her shift, she was required to fill in an induction form, but she stated to me that she did not think that she had to as she worked a shift here about a year before. I explained to the registrant that she was still required to fill in the induction form, which she did but did not include her NMC PIN number.*
>
> *'The registrant did eventually provide her PIN but it was around 00:45hrs before I was in a position to be able to check the NMC Register.'*

The panel took into consideration that you denied the allegation. You stated that when you arrived for your shift on 30 September 2020, you were immediately allocated to attend to a patient due to the busy nature of the ward. You further stated that, when you filled your induction sheet, you could not recall your NMC PIN. Once you were no longer busy with the patient, you went to check for it on your badge which was in your bag and wrote it on the induction sheet.

The panel took into account that Witness 3 confirmed in her oral evidence that at the time she requested for you to fill the induction sheet, you were busy with a patient. She could not confirm the particular time when you provided your NMC PIN as she was busy attending to other work off the ward until after midnight, some hours into the shift.

The panel was of the view that there was insufficient evidence that you had withheld your NMC PIN. It noted that Witness 3 confirmed in both her oral evidence and witness statement that you later provided your NMC PIN.

In this regard, the panel was not satisfied that the NMC had discharged the burden of proof with respect to charge 14c. Accordingly, it found charge 14c not proved.

Charge 15

15. Your actions set out at charge 14c above were dishonest in that you sought to mislead St John and St Elizabeth Hospital and/or undertake work without restriction

This charge is found NOT proved

Having found charge 14c not proved, the panel therefore found charge 15 not proved.

Charge 18

18. Between 1 October 2018 and 30 September 2020 you worked as an Agency Nurse on the Intensive Care Units and community settings at Schedule 2, knowing that you were at all times placed on Supernumerary Practise since August 30 2018 at St Bartholomew's Intensive Care Unit having failed to achieve your ICU Step 1 competencies by July 2017 and having failed to achieve your capability process objectives by June 2019.

This charge is found proved

The panel bore in mind that it had found in charge 11 that it was more likely than not that you failed to achieve your ICU Step 1 competencies by July 2017 and that it was more likely than not that you failed to achieve your capability process objectives by June 2019.

The panel had sight of the email from Barts Matron to Colleague A dated 30 August 2018 in which a decision was made by the Matron to return you to supernumerary practice due to some feedback she had received about your practice. The panel also took account of an undated letter from Colleague A which confirmed that you were placed on supernumerary practice due to concerns about your nursing practice.

The panel next considered whether there was evidence to demonstrate that you had worked for those employers as outlined in Schedule 2. It bore in mind that it had found in charge 5 that it was more likely than not that you worked shifts on 5 and 7 October 2018 as a nurse for Homerton Hospital. It also had sight of the AMC bank timesheets that showed that you had worked those shifts.

The panel bore in mind that you did not dispute that you worked for TCS agency whilst caring for Patient A on 5 and 6 February 2019. This was supported by the oral and documentary evidence of Witnesses 1 and 6. The panel had sight of Thornbury complaint outcome letter dated 10 November 2020 which confirmed that you had earlier worked three-night shifts on 12, 13 and 15 January 2019 whilst caring for Patient A.

The panel also took into account that Colleague F confirmed in her witness statement and the list of shifts worked for Zentar that you had worked in the following hospitals:

a. 27th August 2020- Princess Grace Hospital, ITU
b. 28th August 2020- London Bridge Hospital, ITU
c. 1st September 2020- Wellington Hospital, ITU North
d. 4th September 2020- Wellington Hospital, ITU South
e. 8th September 2020- Wellington Hospital, ITU North

f. 8th September 2020- Wellington Hospital, ITU South
g. 13th September 2020- Bupa Cromwell Hospital, ITU
h. 17th September 2020-London Bridge Hospital, ITU
i. 25th September 2020- Royal Brompton Hospital, AICU/ITU
j. 27th September 2020-Chelsea and Westminster Hospital, ITU
k. 30th September 2020 - St. John & St. Elizabeth's hospital, ITU/HDU

Based on the evidence before it, the panel found charge 18 proved on the balance of probabilities.

Charge 19

19. Your actions at 18 were dishonest in that you sought to mislead the agency, hospital intensive care units and community settings employers at Schedule 2 that you were competent to look after intensive care patients when in fact you were at those times only permitted to be involved in patient care in intensive care settings in a supernumerary capacity.

This charge is found proved

Having found charge 18 proved, the panel went on to consider whether your conduct in charge 18 was dishonest. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance DMA-8. It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited.*

In applying the first limb of the test to charge 18, the panel considered your actual state of knowledge as to whether you sought to mislead your employers in schedule 2: Zentar, AMC and TCS.

In respect of Zentar, the panel had sight of your Zentar application form and noted that you had ticked the ITU skill checklist. You also indicated in the form that Barts was aware of your application to work for Zentar. The panel noted that given that you were

aware of the various feedback on your nursing practice by your supervisors and Colleague A at Barts and you had undergone an informal and formal capability process there, it was reasonable to infer that you knew that you were not competent to look after intensive care patients at the time of your employment for Zentar. The panel was therefore satisfied that it was more likely than not that you sought to mislead Zentar that you were competent to look after intensive care patients when in fact you were at those times only permitted to be involved in patient care in intensive care settings in a supernumerary capacity.

In relation to AMC, the panel took into account that at the time you had worked shifts at Homerton Hospital on 5 and 7 October 2018, you were still working in a supernumerary capacity and you had highlighted that this was one of the reasons for your resignation in 2019. The panel had sight of the NMC telephone log containing the telephone conversation between the NMC and Colleague D. It noted that Colleague D stated that you had notified AMC that you were available to undertake shifts on 5 and 7 October 2018 and you were allocated shifts at Homerton Hospital. He confirmed that when any nurse stated that they were available, the assumption was that they would have obtained permission from their substantive employer to do them.

The panel was of the view that given that you were aware that you were still working in a supernumerary capacity at Barts, when you worked shifts at Homerton Hospital on 5 and 7 October 2018, it was reasonable to infer that you knew that you were not competent to look after intensive care patients at the time of your employment for AMC. The panel was therefore satisfied that it was more likely than not that you sought to mislead AMC that you were competent to look after intensive care patients when in fact you were at those times only permitted to be involved in patient care in intensive care settings in a supernumerary capacity.

With regard to TCS, the panel was of the view that given that you were aware that you were under a formal capability process at Barts, at the time you cared for Patient A in January 2019, it was reasonable to infer that you knew that you were not competent to look after intensive care patients at the time of your employment for TCS. The panel was therefore satisfied that it was more likely than not that you sought to mislead TCS that you were competent to look after intensive care patients when in fact you were at

those times only permitted to be involved in patient care in intensive care settings in a supernumerary capacity

In applying the second limb of the test to this case, the panel was satisfied that your conduct in charge 18 would be considered dishonest by ordinary decent people.

Accordingly, on the balance of probabilities, the panel determined that your conduct in charge 18 was dishonest and it therefore found charge 19 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to a lack of competence and 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 a lack of competence and misconduct. Secondly, only if the facts found proved amount to a lack of competence and misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result.

Submissions on misconduct and lack of competence

Ms Simpeh, on behalf of the NMC, invited the panel to take the view that the facts found proved amount to a lack of conduct and misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Simpeh identified the specific, relevant standards where your actions amounted to a lack of competence and misconduct. In regard to lack of competence she submitted that the evidence from Barts, at charge 11, covers a reasonable sample of your work over a sustained period of time. During this period, you were given multiple opportunities and assistance to improve your skills and competencies but failed to demonstrate improvement. She submitted that your actions were below the standard expected of an experienced registered nurse, placing patients at significant risk of harm, and amounted to a lack of competence.

In regard to misconduct, Ms Simpeh submitted that your actions occurred over a prolonged period of time at numerous places of work, multiple clinical failings, and attitudinal concerns around dishonesty and non-compliance with the NMC. She submitted that these were serious widespread failings that would be considered deplorable by fellow practitioners and collectively amount to misconduct.

Dr Akinoshun submitted that while it is acknowledged that at the time your actions amounted to misconduct and were a serious falling short of the expected standards; your actions did not amount to a lack of competence. He referred to the case of *Zygmunt, R (on the application of) v General Medical Council* [2008] EWHC 2643 (Admin), and that as you had worked as a registered nurse for many years in different hospitals before moving to Barts you were struggling with the new environment and working culture. This led to some clinical mistakes but did not amount to a lack of competence.

Submissions on impairment

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

Ms Simpeh submitted that your actions both in terms of lack of competence and misconduct amount to impairment. She submitted that your actions placed patients at an unwarranted risk of significant harm and were repeated over a prolonged period, in four separate employment situations, with no indication of improvement. She submitted that since the incidents you have not provided any relevant training nor demonstrated remediation in your work as a registered nurse and therefore there remains a risk of harm to patients. Concerning the dishonesty charges found proved, and the practising in breach of an NMC interim conditions of practice order, Ms Simpeh submitted this is evidence of a deep-seated attitudinal concern, that is closely linked to your clinical practice, and placed patients at risk of ongoing harm. She submitted that all four limbs of the test set out in *Grant* are engaged and that your fitness to practice is impaired.

Dr Akinoshun submitted that since the imposition of the interim suspension order there has been a limit on how much remediation you are able to achieve. He submitted that you have secured employment as an HCA since 2022 despite having the option of working elsewhere. He submitted that your employer has provided positive testimonials to your work, including a '*Certificate of Merit'.* He submitted that there has been no further concern raised about your ability to practise safely and that these concerns arose within a discrete period in a long and otherwise unblemished career.

Dr Akinoshun submitted that you have completed a number of continual professional development (CPD) courses that have helped strengthen your practice. He submitted that you have accepted the panels earlier findings on facts, including the ones you denied, and that you are committed to returning to work as a registered nurse. He further submitted that given your recent work as an HCA there would be no repetition of the incidents. He submitted therefore that while in the past you may have been impaired, going forward you are not.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on lack of competence and misconduct

The panel considered that your actions at charge 11 did represent a fair sample of your work and competencies over a suitable timescale. In reaching its decision the panel bore in mind that you should be judged by the standards of the reasonable band 5 registered nurse not by any higher or more demanding standard. The panel noted that over a two year period you were given multiple methods of support and significant feedback to improve, but your performance did not improve. Therefore, the panel determined that your performance demonstrates a lack of competence.

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. The panel noted that this case involved four separate referrals covering a wide range of concerns into both misconduct and lack of competence. In particular, the panel considered the following sections of the Code to have been breached.

> *‘1.2 make sure you deliver the fundamentals of care effectively*
>
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
>
> *9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

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

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

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

20.1 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

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'

Additionally, the panel found that sections: 8.2, 8.3, 8.4, 8.5, 8.6, 10.2, 13.3, and 13.5 were breached.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your actions were a sustained pattern of serious misconduct that falls short of the standards expected of a registered nurse. The panel found that your actions both jointly and severally were serious particularly given that a number of patients were critically dependant on the appropriate nursing care. Of particular concern was that your actions were of a similar nature and repeated over a prolonged period of time therefore the panel determined that they should be considered as a whole and that they do amount to misconduct. The panel considered that a fellow professional would find your actions deplorable.

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 lack of competence and misconduct, your fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional 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*, particularly at paragraph 76, which referred to Dame Janet Smith's "test"; and the NMC guidance on impairment.

The panel finds that your lack of competence put vulnerable patients at unwarranted risk of harm and that this combined with your misconduct, in dishonestly putting yourself forward as a competent ICU nurse, created a substantial risk to patients as well as colleagues in each of the ICU and private settings in which you worked.

The panel finds that patients and relatives, particularly Witness 1, were caused actual physical and emotional harm as a result of your misconduct.

The panel determined that this occurred over a number of workplaces over the course of nearly two years and placed patients at significant risk of serious harm. Your misconduct had breached the fundamental tenets of the nursing profession and brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find the multiple charges relating to dishonesty extremely serious. The panel therefore found all four limbs of the "test" to be engaged.

Regarding insight, the panel considered that you have not provided any reflective piece into your actions, nor demonstrated any remorse at the harm you caused to

patients. While you stated through your representative that you now accept the panel's finding on facts, there is no evidence of reflection on the seriousness of your actions nor any sustained commitment to remediate. The panel had regard to the CPD certificates you submitted; however, the panel considered that it was not sufficient in depth nor adequate in addressing the substantial lack of competence and misconduct identified.

The panel was satisfied that the misconduct in this case is not capable of being addressed. The panel had regard to the significant areas of concern and repeated misconduct that occurred over a prolonged period of time. The panel noted especially the multiple instances of premeditated dishonesty for personal financial gain, that put critically ill patients, requiring specialist ICU care, at serious risk. There has been no reflection, insight, remorse, or remediation into this concern from you. The panel were seriously concerned at the finding of you breaching an interim conditions of practice order imposed by the NMC, and the deliberate disregard this demonstrates towards both your regulator and to the public who were protected by the order. The panel considered all of this to be demonstrative of a deep-seated attitude that is fundamentally opposed to kind, safe, and effective nursing practice.

The panel is of the view that there is a high risk of repetition. The panel therefore 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 the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required in light of the serious concerns identified regarding your utter disregard for the professional standards required for safe effective nursing practice.

The panel concluded that public confidence in the profession would be seriously 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. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Simpeh submitted that a striking-off order would be the only appropriate sanction given the panel's previous findings on impairment and the continued risk of harm to the public. She outlined the aggravating features in this case, including that your actions caused actual physical and emotional harm to patients and the premediated dishonesty for your personal financial gain. She submitted that while you have submitted a reflective piece at this stage of the hearing it is not developed and fails to address the impact your actions had on patients, their families, your colleagues, and the wider public.

Ms Simpeh submitted that given the seriousness of the concerns, particularly the serious dishonesty, a sanction that did not restrict your practice would be wholly inappropriate. She submitted that given your previous failure to comply with an NMC interim order a substantive conditions of practice order is unworkable. She submitted that as the concerns were repeated over a prolonged period of time a suspension

order would not be suitable, and therefore a striking-off order is necessary to protect the public.

Dr Akinoshun submitted that you have taken time after the panel's decision on impairment to reflect and have produced a reflective account this morning. He submitted that you have shown remorse for your actions and the harm caused, you have also reflected on how your practice would be strengthened by the training you have undertaken. He submitted that there a number of mitigating factors, including that this is the only regulatory concern you have faced since becoming a nurse in 1995 and that you have remained working as a HCA in a similar context without further concerns being raised about your conduct. He submitted that a suspension order would be appropriate to mark the seriousness of the concerns identified while allowing you the opportunity to further reflect and develop your practice to return to unrestricted practice in the future.

Decision and reasons on sanction

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

The panel first considered the reflective statement you submitted at the sanction stage of the process. The panel noted that this does express your remorse for your actions and that you offer apologies for what has happened. The panel was concerned that your reflection is at an early stage, failing to acknowledge how your actions fell short of the expected standards, and the panel noted it does not address the issue of premediated dishonesty that occurred over a period of nearly two years.

The panel took into account the following aggravating features:

- Four separate referrals relating to concerns at multiple places of work

- Lack of developed insight into your competence and misconduct and your continued steps to deflect blame on others for your failings
- Actual harm caused to Patient A and to his family
- Dishonest conduct which put critically ill and vulnerable patients at risk of suffering serious harm
- Premediated dishonesty for your personal financial gain
- Serious and sustained dishonesty that occurred for nearly two years
- Deep-seated attitudinal concerns
- Breach of an NMC interim conditions of practice order during the period of your misconduct continuing to place critically ill patients at risk of harm

The panel also took into account the following mitigating features:

- Some early admissions
- You have expressed remorse and apologised for the harm caused in your reflective statement
- Some training completed as an HCA
- Positive testimonials from your current employer in your role as an HCA

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the 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 is of the view that given your lack of insight and previous failure to comply with an interim conditions of practice order there is no evidence that you would comply with a substantive conditions of practice order. The panel determined that as your failings were clinical and attitudinal there were no workable conditions that would protect the public. 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.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

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

The panel found that none of the factors quoted above are present in this case that would indicate a suspension order is appropriate. The panel found that your actions were not a single instance and had been repeated over a prolonged period of time,

and at multiple different places of work. The panel considered that your repeated actions of premeditated serious dishonesty for your personal gain which put critically ill patients at risk of serious harm is strongly indicative of a deep-seated attitudinal concern. The panel considered that there is a high risk of repetition as your actions occurred over a prolonged period of time involving multiple critically ill patients and different working environments.

The panel found that your actions and failures in your practice caused actual harm to Patient A and to his family.

The panel noted that your case does not only involve lack of competence but combines this with misconduct. Therefore, the panel proceeded to consider if the misconduct itself requires to be addressed by a striking-off order.

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 were a significant and sustained departure from the standards expected of a registered nurse, and are fundamentally incompatible with remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were extremely serious and 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 herself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

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

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 Ms Simpeh. She submitted that an interim suspension order for 18 months is necessary on the grounds of public protection and public interest to cover any potential appeal period.

Dr Akinoshun made no submissions in regard of an interim order.

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 as necessary on the grounds of public protection and the public interest to cover any potential appeal period

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

That concludes this determination.