Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 9 April – Tuesday 21 April 2026

Nursing and Midwifery Council

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Babasola Olayinka Babinson**
NMC PIN:	98I4680E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health (Level 1) – 06 April 2002
Relevant Location:	Camden
Type of case:	Misconduct
Panel members:	Bryan Hume (Chair, Lay member) Catherine McCarthy (Registrant member) Paula Newton (Lay member)
Legal Assessor:	Justin Gau (9 – 20 April 2026) Tracy Ayling (21 April 2026)
Hearings Coordinator:	Emma Hotston
Nursing and Midwifery Council:	Represented by Selena Jones, Case Presenter
Mr Babinson:	Present and represented by Dr. Abbey Akinoshun, Erras Consulting
Facts proved:	Charges 1a) i), 1a) ii), 1a) iii), 1a) iv), 1c), 1d), 1e), 1f), 1g), 1h)
Facts not proved:	Charge 1b)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1) On a night shift on 30 August 2023:

    a) Did not manage the restraint of Patient A appropriately in that you:

        i) Allowed colleagues to push her body into the door as she entered her bedroom; and/or

        ii) Allowed colleagues to take Patient A to her bedroom which you knew or ought to have known is not a suitable area/space for intervention; and/or

        iii) Did not plan how the restraint of Patient A would be carried out with staff and/or the Nurse in Charge; and/or

        iv) Did not wait for a response team to be present on the ward before allowing colleagues to carry out the restraint on Patient A.

    b) Held Patient A by the neck and/or strangled Patient A;

    c) Allowed colleagues to hold Patient A by the neck and/or strangle Patient A;

    d) Slapped Patient A on one or more occasions;

    e) Threw liquid/water at Patient A;

    f) Held Patient A's head while she lay prone on her bed;

    g) Failed to document the conduct described in charges 1b and/or 1c and/or 1d and/or 1e and/or 1f.

    h) Your conduct at Charge 1g was dishonest in that you attempted to conceal your own and/or your colleague's actions towards Patient A.

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

Background

The charges arose whilst you were working as a Bank Mental Health Nurse at the Central and North West London NHS Foundation Trust ('the Trust'), where you had been working since 2018. Following a referral by the Trust, an investigation was conducted by the Nursing and Midwifery Council (NMC) in relation to an incident that is said to have taken place on [PRIVATE] ('the Ward') at the Trust on the night shift of 30 - 31 August 2023.

On 1 September 2023 it was brought to the attention of colleagues at the Trust that you had allegedly assaulted Patient A during the night shift of 30 - 31 August 2023. This incident was reported by the patient and members of staff present. Injuries were noted on Patient A's body immediately after the incident, including bruising to their face, neck and arm.

On the night shift of 30 - 31 August 2023, it is alleged that Patient A became agitated when a computer she was working on in the activity room was not functioning properly. At approximately midnight, patients were instructed to leave the activity room and return to their bedrooms. Patient A refused and became increasingly distressed. A team decision was taken to require Patient A to return to her room.

You were one of the most senior members of staff on duty at the time and oversaw the care of two healthcare assistants who removed Patient A from the computer room. As the most senior member of staff present, it was your responsibility to supervise and manage the intervention. It is alleged that Patient A was placed in a prone position on her bed, at which point you took over the restraint of Patient A. It is alleged that your restraint of Patient A had been inappropriate in that you held Patient A's head face down on the bed whilst another healthcare assistant restrained her body. It is further alleged that you repeatedly slapped Patient A and threw a cup containing an unidentified liquid over her.

Patient A sustained injuries to her body and arms, and photographic evidence of these injuries has been provided.

Following this incident, the Trust commissioned a formal disciplinary investigation and your contract with the Trust's bank was terminated.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Jones, on behalf of the NMC, under Rule 31 to adduce four witness statements into evidence as hearsay. These statements record email and telephone conversations between a solicitor employed by Weightmans on behalf of the NMC, and the witnesses, in addition to local witness statements and interviews included as part of the local trust investigation.

Ms Jones submitted that the NMC applies to admit the statements of four witnesses, namely Mr Augustine Denila, Ms Ejatu Sesay, Ms Justina Buiro and Mr Mujeeb Alesinloye, as hearsay. Ms Jones submitted that these statements are relevant evidence. She submitted that each of the four witnesses were contacted by the NMC and indicated a willingness to provide evidence. Ms Jones further submitted that these statements, whether considered individually or collectively, are not the sole or decisive evidence in relation to the charges.

Ms Jones submitted that despite reasonable and proportionate efforts, the NMC has been unable to secure the attendance of these four witnesses at the hearing. Numerous attempts were made to contact Mr Denila, including at his last known address, but these efforts were unsuccessful. Ms Sesay did not attend a telephone interview arranged for 24 October 2025. In relation to Ms Buiro, a voicemail was left on 28 October 2025 and further attempts were made to contact her. A telephone call took place on 31 October 2025; however, no further response was received and, although evidence was sent to her for review, she did not respond. An interview with Mr Alesinloye was scheduled for 12 November 2025 but he did not attend. A further telephone call on 25 November 2025 was

terminated by him, and a subsequent call arranged for 16 December 2025 was also not attended. In these circumstances, the NMC submits that there is proper justification for admitting this evidence as hearsay.

Dr Akinoshun, on your behalf, opposed the NMC's application to admit the statements of these four witnesses into evidence, as hearsay. He submitted that the application should be considered in light of the NMC's guidance on hearsay, in particular the requirements of fairness and the interests of justice. He submitted that the panel must balance the relevance and value of the evidence against the need for it to be properly tested.

Dr Akinoshun submitted that the hearsay evidence sought to be admitted directly relates to charges 1b) to 1h), which are serious allegations going to the heart of your integrity and fitness to practise. In those circumstances, he submitted that the evidence should be subject to proper scrutiny and cross-examination. He submitted that admitting the hearsay application would deprive you of the opportunity to test the reliability of the witnesses and that it would be unsafe for the panel to place weight on such evidence in a case of this gravity. He further submitted that the only evidence in the witness bundle that directly relates to charges 1b) to 1h) is that of Patient A, which is not sufficiently reliable to justify a reliance on hearsay.

Dr Akinoshun submitted that he has significant concerns regarding the consistency and reliability of the witnesses' accounts. He submitted that although all four witnesses were present at the same incident, their accounts differ. Ms Sesay refers to you splashing water at Patient A but makes no allegation that you slapped her. Mr Alesinloye describes you slapping Patient A and provides a detailed account of events. Ms Buiro states that she witnessed repeated slapping of Patient A by you, whereas Mr Denila describes you as 'heavy handed' but does not allege that you slapped Patient A. Dr Akinoshun submitted that these discrepancies in accounts can only properly be explored through cross-examination.

Dr Akinoshun submitted that many of the witness statements and interview notes included in the statements are unsigned. He submitted that the only signed statement appears to be that of Ms Sesay, and that various interview notes and statements relating to the other four witnesses are not signed. He submitted that these deficiencies further undermine the reliability of the evidence.

Dr Akinoshun further submitted that he sent an email to the NMC on 27 March 2026 indicating that he opposed the inclusion of the four witness statements within the exhibit bundle, as they were not included within the witness bundle. He submitted that this email was sent further to a pre-meeting which took place on 6 March 2026, at which it was agreed that any issues, including redactions, would be raised by a specified date.

Dr Akinoshun submitted that, in light of the seriousness of the allegations, the inconsistencies between the four witness accounts, and the deficiencies in the evidential material, it would be unjust and unsafe to admit the four witness statements as hearsay. He invited the panel to refuse the NMC's application and to require the attendance of the four witnesses to give live evidence which can be tested under cross-examination.

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

Decision and reasons for hearsay application

The panel noted the four witness statements that the NMC has applied to admit as hearsay, namely that of Mr Denila, Ms Sesay, Ms Buiro and Mr Alesinloye. The panel was satisfied that the statements were either contemporaneous or made very near the time of events. The panel considered each of the witness statements, assessing the fairness and relevance of admitting them into evidence. The panel was satisfied; that the statements individually and collectively were not the sole and decisive evidence in support of any of the charges, there was no suggestion that the witnesses had fabricated the evidence, the NMC had taken reasonable steps to secure the attendance of the witnesses, the charges were serious and should be investigated properly, and you had been given proper notice

that this application was to be made at a pre-meeting on 6 March 2026. The evidence of these witnesses can be tested against the evidence of other witnesses who are attending, and appropriate weight can be given to these statements at the conclusion of all the evidence.

The panel determined to admit the four witness statements into evidence.

Decision and reasons on facts

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

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

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

- Patient A: Was a patient on the Ward at [PRIVATE] ('the Hospital'), Central and North West London NHS Foundation Trust ('The Trust'), who was allegedly assaulted by you.

- Ms Lucia Perera: Held the role of Staff Nurse at [PRIVATE] ('the Hospital'), Central and North West London NHS Foundation Trust ('The Trust'), at the material time.

- Mr Paul Russell: Held the position of Service Manager for Tri-borough Learning Disability Services at Central and North West London NHS Foundation Trust ('The Trust') and was the investigating officer on this case at the material time.

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. It considered the witness and documentary evidence provided by both the NMC, and your representative Dr. Akinoshun, on your behalf.

The panel was hampered in its fact-finding exercise due to the fact that the incident was unexpected and chaotically managed. It was further hindered in its fact-finding exercise due to the fact that some individuals had attempted to cover-up or minimise their poor behaviour. The panel was assisted by the CCTV footage and the clear oral evidence of both Patient A and Mr Paul Russell.

Before making its decision on the facts for each sub-charge, the panel first determined that having reviewed the CCTV footage, there was no evidence that Patient A had damaged any computers or furniture in the games room, prior to the intervention. It noted that there is CCTV footage of Patient A working on the computer when you and your colleagues arrived. Although there was no audio to the CCTV, Patient A appears to be sitting calmly, not displaying any aggressive behaviours. A female member of staff, Ms Sesay can be seen to be standing by Patient A in a relaxed attitude. There were no other patients in the room. You can be seen to speak Ms Sesay and gesture towards the door, indicating that she should leave. Mr Denila and Mr Adesinloye can be seen to remove the furniture from around Patient A. Each of those individuals took hold of one of her hands. The panel could discern no clear reason for you and your colleagues to restrain Patient A.

The panel determined that you did not follow the Trust Use of Force policy in carrying out the restraint, as there was no third person supporting Patient A's head throughout the process, as outlined as a requirement in the policy. The panel further noted that the policy outlined the requirement for the physical restraint team to be of an appropriate size and gender to the Patient being restricted. The policy also states that when a female is being restrained, there must be a female member of staff present, even if they are not actually involved in the restraint. The panel determined that it was your responsibility to control and plan this restraint, as the most senior nurse present at the time of the incident.

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

Charge 1a) i)

> "That you, a registered nurse, on a night shift on 30 August 2023:
> a) Did not manage the restraint of Patient A appropriately in that you:
> i) Allowed colleagues to push her body into the door as she entered her bedroom."

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence.

The panel first considered the CCTV footage of [PRIVATE] ward, outside the gym door. It was of the view that the CCTV clearly showed Patient A's body being pushed into the closed door by two healthcare assistants, Mr Denila and Mr Adesinloye, forcing her to enter her bedroom, whilst you stood approximately two feet behind them. The panel noted that you are looking straight at Patient A as she is pushed into the door and do not move your head away at any stage. The panel was of the view that you could see the incident clearly and made no attempts to intervene to ensure that the Trust Use of Force policy was followed appropriately.

The panel noted from the Trust Use of Force policy that the restraint should be carried out by a minimum of three people, with one person holding the patient's head. It states:

> *'A minimum of three members of staff are recommended for the safe implementation of physical intervention - one for each arm and one supporting the aroused Patient's head.'*

In regard to door management, the policy states:

> *'If the patient is posing a challenge, then it is expected that a both staff or an identified member of staff would support the patient's head as the team enter the doorway side on.'* [sic]

The panel noted from the CCTV footage that you did not appear to take any actions to protect Patient A's head as she was pushed into the door.

The panel then took into account your oral evidence where you say that Patient A spat at Mr Denila and that some of the spittle landed on your face. The panel was satisfied that this shows how close you were to Patient A as she was pushed into her bedroom. The panel reject your explanation that you did not see this event and was satisfied that you were clearly looking directly looking at Patient A as she was pushed through the door.

The panel determined that by not intervening, you did not manage the restraint of Patient A appropriately in that you allowed colleagues to push her body into the door as she entered her bedroom. Furthermore, by not taking actions to protect Patient A's head during the restraint, you did not follow the Trust Use of Force policy appropriately. Therefore, the panel found that charge 1a) i) was proved.

Charge 1a) ii)

> "That you, a registered nurse, on a night shift on 30 August 2023:

a) Did not manage the restraint of Patient A appropriately in that you:
ii) Allowed colleagues to take Patient A to her bedroom which you knew or ought to have known is not a suitable area/space for intervention."

This charge is found proved.

The panel first considered the CCTV footage of [PRIVATE] ward, outside the gym door. It noted that it was clear from the CCTV footage that Patient A had been taken to her bedroom by you and your colleagues during the restraint.

The panel next considered the oral evidence of Patient A, who stated that she had been taken to her bedroom during the restraint. This account is consistent with Patient A's written statement, which stated:

> *'A member of staff called Mujeeb was there and Augustine said to Mujeeb that I wasn't listening to him and to grab my arm. Augustine grabbed me with force and I said I am happy to walk out and that I wasn't resisting. Augustine then pushed me into my room and onto my bed and was punching my face and body.'* [sic]

The panel further noted in Patient A's oral evidence she stated that it appeared to be normal practice on [PRIVATE] ward for patients to be taken to their bedroom, rather than the de-escalation room.

The panel next considered the oral evidence of Ms Lucia Perera. During her evidence, she was shown the CCTV footage of the games room for the first time. She stated that this showed a different factual scenario to that which had been explained to her by you after the incident and she was plainly shocked by the behaviour of you and your colleagues in the games room. She also explained that there is a de-escalation room on [PRIVATE] ward which is a suitable area/space for intervention and that in her opinion, the de-escalation room would have been a more appropriate area for intervention than Patient A's room. This is consistent with Ms Perera's written statement, where she stated:

‘I understand that following the restraint, Patient A was taken to her room. However, the games room is next to the de-escalation room, so it would have been easier for Yinka and the other members of staff restraining Patient A to take her there. The de-escalation room has a safety pod, so it’s the best place for patients to go when they need to calm down. However, since Yinka was not a regular member of staff on the Ward, he may not have known to take Patient A there. Again, as I was not present for Patient A’s restraint, I cannot speculate as to why Patient A was taken to her bedroom, rather than the de-escalation room.’

The panel noted that Ms Perera stated in her oral and written evidence that as you were bank staff you may not have been aware of the de-escalation room.

The panel then took into account your oral evidence. It noted that you said in your oral evidence that you were aware of a seclusion room as a suitable area/space for the intervention with patients and stated that this room was used as a last resort. You said that that Patient A was very aggressive and posed a risk of harm to other patients. You stated that you moved Patient A to her bedroom to allow her to calm down before she returned to the games room.

The Trust Use of Force policy states that ‘*seclusion should be used where it is of immediate necessity due to severe behavioural disturbance which is likely to cause harm to others*.’ You could give no explanation to the panel as to why Patient A was not placed in seclusion rather than in her bedroom given that your explanation was that she was behaving in a manner consistent with severe behavioural disturbance.

The panel also noted in your own incident report that you state that ‘*Patient A demanded again to be taken to the seclusion room, otherwise she would break the ward down*.’

Furthermore, the panel considered the Trust Use of Force policy, which outlined that patients should be moved to a safe place in de-escalation interventions:

> *'Try to move towards a safe place - this means an area where the Patient will feel secure, and where staff have access to an escape route should this be necessary. Staff will be aware of exits routes at all times during a management of aggression situation.'*

The panel was of the view that in line with the Trust Use of Force policy, the de-escalation/ seclusion room would have been the most suitable space for intervention.

In light of this, the panel determined that you did not manage the restraint of Patient A appropriately in that you allowed colleagues to take her to her bedroom which you knew is not a suitable area/space for intervention.

Therefore, the panel found that charge 1a) ii) was proved.

Charge 1a) iii)

> "That you, a registered nurse, on a night shift on 30 August 2023:
> a) Did not manage the restraint of Patient A appropriately in that you:
> iii) Did not plan how the restraint of Patient A would be carried out with staff and/or the Nurse in Charge."

This charge is found proved.

The panel first considered your oral evidence. It noted your explanation that you planned with colleagues to initially use talking therapies with Patient A to help her to calm down. You stated that your plan for how the restraint of Patient A would be carried out was discussed with Ms Perera and your two colleagues. Ms Perera was the Nurse in Charge

on the night of the incident. In her oral evidence Ms Perera denied knowing about the plan for restraint.

You stated that as part of the plan for the restraint of Patient A, you asked Mr Adesinloye to take Patient A's left hand and Mr Denila to take her right hand, to prevent Patient A from hurting herself.

The panel next considered the Trust Use of Force policy which states that restraint should be carried out by people of a similar or appropriate size and sex to the patient. It states:

> *'Where possible, the physical restraint team should be of an appropriate size and gender to the Patient being restricted. At least one Patient of the same gender as the Patient being restrained must be present throughout the restraint. When a female is being restrained there must be a female member of staff present at ALL times, even if they are not actually involved in the restraint.'*

The panel noted that in your oral evidence, you stated that you are five feet ten inches tall, and in her oral evidence, Patient A stated that she is five feet two inches tall. It noted that the restraint was carried out by two male colleagues, Mr Denila and Mr Adesinloye who were much larger than Patient A. It was of the view that the CCTV clearly showed that a female member of staff, Ms Sesay, had been present in the games room prior to the time of the restraint. The panel noted that whilst Ms Sesay had not completed the Prevention and Management of Violence and Aggression (PMVA) training, it would have been possible for her to be present in the room at the time of the restraint. It also appeared that she was asked to leave the games room by you. It also noted from Ms Perera's oral evidence that she was available on [PRIVATE] ward at the time of the restraint.

The panel next considered your local statement at the time of the incident, where you stated that you were '*not up to date with the PMVA training*.' The panel noted that this differed to the evidence in your local interview, where you stated that you were '*up to date with the use of force training*.' Furthermore, in response to a question from the panel as

part of your oral evidence, regarding whether your PMVA training was up to date at the time of the incident, you confirmed that it was up to date.

In your local statement, you stated:

'Patient A was restrained into her room using PMVA techniques as she was spitting a chunk of phlegm into my face and AD's face.' [sic]

The panel was of the view that you did not manage the restraint of Patient A appropriately in that it had no evidence that you had discussed a full plan for how the restraint of Patient A would be carried out with staff and/or the Nurse in Charge, nor did you follow the trust restraint policy appropriately. Accordingly, the panel found that charge 1a) iii) was proved.

Charge 1a) iv)

> "That you, a registered nurse, on a night shift on 30 August 2023:
> a) Did not manage the restraint of Patient A appropriately in that you:
> iv) Did not wait for a response team to be present on the ward before allowing colleagues to carry out the restraint on Patient A."

This charge is found proved.

The panel first considered your oral evidence where you stated that you pressed the alarm bell for the response team. It noted your explanation that the situation was urgent, and you believed that it would take too much time for the response team to arrive before allowing colleagues to carry out the restraint on Patient A. The panel has already noted that Patient A was seen to be sitting calmly at the computer desk when you and your colleagues entered the games room. The panel reject your explanation that she was causing physical damage and was shouting. Even if that was the case at an earlier time, this does not justify your use of force at the time of the physical intervention.

The panel next considered the CCTV footage of the games room. The CCTV showed that just 39 seconds passed between you entering the games room and allowing colleagues to carry out the restraint on Patient A. The panel was of the view that it is clear from the CCTV footage that you did not allow sufficient time for a response team to arrive before carrying out the restraint on Patient A. Furthermore, the panel noted that it had no evidence before it to indicate why you did not spend longer using talking therapies with Patient A to help her to calm down, as in your oral evidence you stated that she was being aggressive, before allowing colleagues to carry out the restraint.

In light of this, the panel determined that you did not manage the restraint of Patient A appropriately in that you did not wait for a response team to be present on the ward before allowing colleagues to carry out the restraint on Patient A. Therefore, the panel found that charge 1a) iv) was proved.

Charge 1b)

> "That you, a registered nurse, on a night shift on 30 August 2023:
> b) Held Patient A by the neck and/or strangled Patient A."

This charge is found NOT proved.

The panel first considered the oral evidence of Patient A who stated that you did not hold her by the neck and/or strangled her. She stated in her oral evidence that it was Mr Denila that held her by the neck and/or strangled her.

The panel next considered that Patient A's account differed to the local interview with Ms Sesay, which stated:

> *'Yinka was holding her neck, she said "why are you hurting me why are you strangling me". Then I told Yinka to take it easy.'*

The panel then took account of your oral evidence and noted that whilst you stated that you were standing next to Patient A's head at the time of the restraint, you denied holding her by the neck and/or strangling her.

In light of this, the panel determined that the NMC has not discharged the burden of proving on the balance of probabilities that you held Patient A by the neck and/or strangled Patient A. Therefore, the panel found that charge 1b) was not proved.

Charge 1c)

> "That you, a registered nurse, on a night shift on 30 August 2023:
> c) Allowed colleagues to hold Patient A by the neck and/or strangle Patient A."

This charge is found proved.

The panel first considered the oral evidence of Patient A. It noted that during her oral evidence, she explained that Mr Denila held her by the neck and/or strangled her. The panel found Patient A's oral evidence to be credible, and it was consistent with her written statement, which stated:

> *'The injuries I sustained were bruising to my upper arm and a scratch to my neck from when Augustine was choking me and neck was also red. I do have a lasting injury to my jaw which now clicks, for instance if I eat an apple hard for me to bite.'*

The panel went on to consider the photos taken after the incident, which clearly demonstrated injuries to Patient A's neck. It was of the view that these were significant and were likely to have been caused by Patient A being held by the neck and/or strangled.

The panel considered the Trust Use of Force policy which stated:

‘Physical restraint must never involve compression of a Patient’s neck. Neck holds must never be used.’

The panel then took into account your oral evidence. It noted that you stated that the restraint was controlled.

In his local interview, in response to a question regarding why there was bruising around Patient A’s neck, Mr Denila stated:

‘It definitely was not me - may have been someone else.’ [sic]

The panel was of the view that as the photos of Patient A’s neck demonstrate significant injury, it was satisfied that the restraint was not controlled and that someone held Patient A by the neck and/or strangled her. Furthermore, the panel was of the view that as the most senior nurse present at the time of the incident, you should have intervened to stop colleagues from holding Patient A by the neck and/or strangling her.

In light of this, the panel determined that you allowed colleagues to hold Patient A by the neck and/or strangle Patient A. Therefore, the panel found that charge 1c) was proved.

Charge 1d)

“That you, a registered nurse, on a night shift on 30 August 2023:
d) Slapped Patient A on one or more occasions.”

This charge is found proved.

The panel first considered the oral evidence of Patient A. It noted that during her oral evidence, Patient A explained that you slapped her on one or more occasions. This was consistent with her written statement.

The panel next considered the local interviews of Ms Buiro, Mr Adesinloye and Ms Sesay.

Ms Buiro stated:

> *'Yinka was slapping the girl, beating her and she was on the floor. It did not look like the way a restraint should be. She was on the floor. Augustine was holding her…. She was on the floor and he was reaching down to her, slaps possibly on the face. I know he was beating her repeatedly, it was not one slap, maybe 2 or 3, it was quick. It had to have been hard because she went mad and she was upset and shouting. Augustine asked Patient A to stop.. Augustine did not stop Yinka from hitting Patient A. No one stopped Yinka from hitting Patient A. All I saw was him beating the girl..'* [sic]

Mr Adesinloye stated:

> *'When she spat in Yinka's face she turned and spat at Yinka and he lost it. As soon as he spat, he slapped her.'* [sic]

Ms Sesay also stated that you slapped Patient A after the water throwing.

The panel was of the view that these witness statements corroborate the evidence of Patient A.

In light of this, the panel determined that there are multiple witness accounts that you slapped Patient A on one or more occasions. Therefore, the panel found that charge 1d) was proved.

Charge 1e)

> "That you, a registered nurse, on a night shift on 30 August 2023:
> e) Threw liquid/water at Patient A."

This charge is found proved.

The panel first considered the oral and written evidence of Patient A who stated that you threw liquid/ water at her. The panel noted in Patient A's evidence that she stated that she threw liquid at you and that you threw liquid back at her. The panel determined that Patient A was a credible witness and was consistent across her oral and written evidence.

The panel went on to consider the CCTV footage of [PRIVATE] ward, outside the gym door. It noted that the footage clearly demonstrates Patient A throwing liquid at you. You are then seen running back into her room and coming out with what appeared to be a cup in your hands.

The panel next considered the witness statement of Ms Sesay, which was accepted into evidence as hearsay. Ms Sesay stated that:

> *'While M and I were still trying to calm Patient A down by calmly talking to her, I saw staff YB coming out of Patient A bathroom holding a cup filled with dirty water. He splashed it at Patient A and took her unaware, this made Patient A emotional and more aggressive toward YB. Patient A and staff YB started throwing fists at each other.'* [sic]

Furthermore, the panel noted that Ms Sesay's account was consistent with the evidence in her local interview, where she stated:

> *While Patient A was venting out and make sure that they have being dealt with, Yinka went into the bathroom and came out with a cup and splashed it on Patient A. Yinka slapped Patient A, and I told him this is not right, I was not happy with that at all.'* [sic]

The panel was of the view that the evidence from Ms Sesay corroborated the oral and written evidence of Patient A.

In light of the CCTV footage and witness evidence from Patient A and Ms Sesay, the panel determined that you threw liquid/water at Patient A. Therefore, the panel found that charge 1e) was proved.

Charge 1f)

> "That you, a registered nurse, on a night shift on 30 August 2023:
> f) Held Patient A's head while she lay prone on her bed."

This charge is found proved.

The panel first considered the oral evidence of Patient A who stated that she did not lay prone on the bed. The panel noted that Patient A stated that she was 'thrown to the bed.'

The panel next considered the written statement of Mr Adesinloye which was accepted into evidence as hearsay. In his written statement, Mr Adesinloye states that Patient A was put face down on her bed in the prone position. He stated:

> *'As she sat down we put her in a prone position... We have gone in and it is quite awkward as the bed is on the wall, we sat then put her in prone position...'* [sic]

The panel then took into account of your oral evidence and noted your explanation that Patient A was lay prone on her bed and that you held her head to the side as part of a safe restraint manoeuvre.

The panel determined from your oral evidence that you admitted that you held Patient A's head while she lay prone on her bed. Furthermore, the panel was of the view that you did not follow the Trust Use of Force policy appropriately. Therefore, the panel found that charge 1f) was proved.

Charge 1g)

"That you, a registered nurse, on a night shift on 30 August 2023:
g) Failed to document the conduct described in charges 1b and/or 1c and/or 1d and/or 1e and/or 1f."

This charge is found proved.

The panel first considered the Datix report which you completed following the incident. It noted that the Datix report omitted information that you allowed colleagues to hold Patient A by the neck and that you slapped her and threw liquid/water at her. In the Datix report, under action taken, it stated:

'Alarm was activated. She was restrained into her room using PMVA techniques and de-escalation employed. Following de-escalation she was offered PRN Lorazepam (not as rapid tranquiliser) which was taken with no effect. Bleep Holder informed and staff responded from other wards. Vital signs requested and she refused all offers. Telling staff to fuck off. Computer room was opened for her to de-escalate herself following further de-escalation, IM Aripiprazole 9.75mg was administered, not as rapid tranquiliser. Staff and Patient A were debriefed on the incident. attempt made to debrief service user.'

Furthermore, the panel noted that the Datix report omitted information that Patient A was placed in the prone position. The panel noted that this differed from your oral evidence where you stated that you held Patient A's head whilst she was prone, as part of a safe restraint manoeuvre.

The panel was of the view that you purposefully omitted key information that took place on the night shift on 20 August 2023 and that in your role as the most senior nurse on duty at the time of the incident, you should have included information in the Datix report that you

allowed colleagues to hold Patient A by the neck and that you slapped her and threw liquid/water at her.

The panel noted that charge 1b) was found not proved. Having reviewed all of the evidence, the panel determined that you failed to document the conduct described in charges 1c) and/or 1d) and/or 1e) and/or 1f). Therefore, the panel found that charge 1g) was proved.

Charge 1h)

"That you, a registered nurse, on a night shift on 30 August 2023:

h) Your conduct at Charge 1g was dishonest in that you attempted to conceal your own and/or your colleague's actions towards Patient A."

This charge is found proved.

The panel first considered the CCTV footage of [PRIVATE] ward, including the footage of the games room and outside the gym door, and noted that you were present at all times during the restraint of Patient A and were therefore aware of the incidents that occurred on the nightshift of 30 August 2023.

The panel was of the view that you did not document the conduct described in charges 1c) and/or 1d) and/or 1e) and/or 1f). Furthermore, the panel determined that having found charge 1g) proved, that you purposely omitted key information from the Datix report in order to conceal your own and/or your colleague's actions towards Patient A.

The panel took account of your oral evidence where you stated that you held a debrief with your colleagues following the incident, where '*no one said anything*' regarding the conduct that had occurred on the nightshift. The panel considered that your account differed to the evidence in the witness statement of Ms Sesay, admitted into evidence as hearsay, which stated:

‘During the debrief, I explained that certain things could have been done better, I also made staff YB aware that I was not happy with his approach and his actions. He said he would do the incident report and detail all that had happened and do a comprehensive note on all that occurred.’ [sic]

The panel was of the view that your conduct at Charge 1g was dishonest in that by omitting key details from the Datix report, you attempted to conceal your own and/or your colleague’s actions towards Patient A.

Therefore, the panel found that charge 1h) was proved.

Fitness to practise

Having reached its determination on the facts of this case the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether 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 safely and effectively without restriction.

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

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

Submissions on misconduct

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

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

Ms Jones submitted that your actions fell seriously short of the standards expected of a registered nurse and amount to misconduct. She identified the specific, relevant standards where your actions amounted to misconduct and submitted that your actions amounted to a breach of the Code under 20.1, which relates to '*keep to and uphold the standards and values set out in the Code'* and 20.8, which relates to *'act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to.'*

Ms Jones submitted that the concerns in this case are serious and have been found proved. This includes the slapping of Patient A, causing significant injuries, acts of dishonesty, permitting colleagues to hold Patient A by the neck, throwing liquid over Patient A, and holding her head whilst she was in a prone position in her bedroom. These are serious departures from the fundamental standards of care, professionalism, and patient safety required of you as a registered nurse.

Ms Jones submitted that you did not admit the facts at the outset. Whilst you demonstrated, during your evidence, how you held Patient A's head, this was not an early admission. She submitted that you were evasive in your evidence, which further aggravates the seriousness of the concerns.

Ms Jones submitted that your behaviour is deep-seated and attitudinal in nature. This case involves dishonesty, which is inherently more difficult to remediate. Your actions were not momentary lapses but reflect a concerning approach to patient care and professional responsibility, particularly given that you were a senior member of staff at the time.

She submitted that nurses occupy a position of trust and responsibility and your conduct represents a serious breach of that trust. In all the circumstances, Ms Jones invited the panel to find that the matters found proved amount to misconduct.

Dr Akinoshun submitted that you are entitled to deny the charges, and in this case, you have exercised that right. He submitted that the panel has now heard all of the evidence in relation to the charges and has made findings of fact.

Dr Akinoshun reminded the panel of the facts found proved and submitted that, when considering whether those facts amount to misconduct, your wider professional history is highly relevant.

Dr Akinoshun submitted that there have been no previous concerns regarding your conduct, attitude, or clinical practice. No similar allegations have ever been made against you throughout your career. Since qualifying as a nurse in 2001, you have worked with a wide range of patient groups and have maintained an otherwise unblemished record. He therefore invited the panel to take into account your long-standing career and previous good character when determining whether the matters found proved are sufficiently serious to amount to misconduct.

Submissions on impairment

Ms Jones moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession

and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Jones submitted that your fitness to practise is currently impaired.

She submitted that you have had the opportunity during these proceedings to reflect on your actions and demonstrate insight. The panel has also had the opportunity to assess your thought processes at the time of the incidents. However, she submitted that you remain liable to repeat the concerns found proved.

Ms Jones submitted that despite the passage of two years and seven months since the incident, you have provided insufficient evidence of meaningful remediation. At this stage of proceedings, you would be expected to have demonstrated clear insight, genuine remorse, and evidence that your practice has improved as a result of reflection. However, she submitted that your mindset remains unchanged.

She submitted that even after reviewing the CCTV evidence and hearing the full extent of the concerns, you have not demonstrated a material shift in your view as to whether the restraint of Patient A was appropriately managed. This indicates a continuing lack of insight into the seriousness of your actions.

Ms Jones further submitted that you have not demonstrated any evidence of genuine remorse. Your responses and approach throughout these proceedings suggest that you have not fully acknowledged the seriousness of your conduct.

She submitted that given the seriousness of the findings, the attitudinal nature of the behaviour, and the lack of demonstrated remediation, there remains a real risk of repetition. This engages the need to protect the public and uphold proper professional standards.

Accordingly, Ms Jones invited the panel to find that your fitness to practise is currently impaired.

Dr Akinoshun submitted that your fitness to practise is not currently impaired. He submitted that you have taken the concerns seriously, irrespective of whether you admitted the charges. You have undertaken a range of relevant training to address the issues identified. This includes PMVA training completed in 2024 and 2025, training on professional accountability, a course in effective communication in healthcare, and training on stress cognition and solutions. These are evidenced by the certificates before the panel. He submitted that these steps demonstrate a proactive approach to remediation.

Dr Akinoshun next submitted that you have demonstrated insight and reflection. You recognise the importance of professional communication, patient safety, and accountability. Your reflective statement outlines what you would do differently in future, and he submitted that this should be given appropriate weight.

Dr Akinoshun submitted that you have demonstrated safe practice since the incident. You continued working through a nursing agency with patients who exhibit challenging behaviour up until April 2024, and no further concerns have been raised about your practice during that time. This indicates that the risk of repetition is low.

Dr Akinoshun submitted that your inability to secure employment since the imposition of the interim conditions of practice order should not be held against you. You have been open, honest, and transparent with prospective employers in compliance with those conditions. You have made proactive efforts to seek work, including contacting hiring managers prior to submitting applications. The lack of documentary evidence of these efforts and the absence of references from the agency are explained by circumstances beyond your control, including the agency’s decision not to provide a reference following the imposition of conditions.

Dr Akinoshun further submitted that your previously unblemished career, the passage of time since the incident, your subsequent safe practice, and the remedial steps you have taken all support the conclusion that the concerns have been addressed.

In light of these factors, Dr Akinoshun invites the panel to find that: 1) the passage of time and your safe practice since the incident demonstrate no ongoing concerns; 2) Your current unemployment is a consequence of the interim conditions and full disclosure requirements, rather than any ongoing risk; 3) You have demonstrated sufficient insight and reflection; 4) The risk of repetition is now low.

Accordingly, Dr Akinoshun submitted that your fitness to practise is not currently impaired.

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

Decision and reasons on misconduct

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

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

> ***Prioritise people***
>
> ***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*

1.1 *treat people with kindness, respect and compassion*

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

1.5 *respect and uphold people's human rights*

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:

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

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

To achieve this, you must:

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

Practise effectively

8 Work cooperatively
To achieve this, you must:

8.2 *maintain effective communication with colleagues*

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

Promote professionalism and trust

20 Uphold the reputation of your profession at all times
To achieve this, you must:

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

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

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

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

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

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

The panel found that the following charges in particular amounted to serious misconduct, including 1a) not managing the restraint of Patient A appropriately in that you, 1a) i) allowed colleagues to push her body into the door as she entered her bedroom, 1a) ii) allowed colleagues to take Patient A to her bedroom which you knew or ought to have known is not a suitable area/space for intervention, 1a) iii) did not plan how the restraint of Patient A would be carried out with staff and/or the Nurse in charge, and 1a) iv) did not wait for a response team to be present on the ward before allowing colleagues to carry out the restraint on Patient A. In relation to charge 1a) iii), the panel noted from the oral evidence of Ms Perera that she was not aware of the plan for restraint, which you had claimed in your oral evidence had been discussed with her and colleagues. The panel was of the view that you had attempted to mislead them during your oral evidence.

The panel found that charges 1c) allowed colleagues to hold Patient A by the neck and/ or strangle Patient A, 1d) slapped Patient A on one or more occasions, 1e) threw liquid/water at Patient A, and 1f) held Patient A's head while she lay prone on her bed, also amounted to serious misconduct. The panel noted that you did not admit to any of the charges now found proved and although you demonstrated in your evidence how you held Patient A's head while she lay prone on her bed, you did not admit this from the outset, demonstrating serious attitudinal concerns.

Furthermore, the panel noted that the misconduct related to dishonesty in charges 1g) and 1h), whereby you attempted to conceal your own and/or your colleagues actions towards Patient A by failing to document the conduct described in charges 1c), 1d), 1e) and 1f), further demonstrates deep-seated attitudinal concerns.

The panel noted that all of these breaches of the code were particularly serious and it had evidence that physical and emotional harm was caused to Patient A as a result of your misconduct. The panel also noted that you abused your position of trust as a Registered Mental Health Nurse.

In the panel's judgement, this behaviour was a serious departure from the standards expected of a registered nurse and amounts to serious misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

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

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

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

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel first considered whether any of the limbs of the Grant test were engaged as to your past conduct. The panel finds that Patient A was placed at unwarranted risk of harm and caused physical and emotional harm as a result of your misconduct. The panel noted that Patient A was vulnerable, it was her first experience in mental health hospital and her first experience of being restrained. The panel was of the view that to have received this behaviour would have a significant negative physical and emotional impact on her.

The panel found that your misconduct constituted a serious breach of fundamental tenets of the nursing profession in that you failed to prioritise people, practise effectively and promote professionalism and trust. It determined that you failed to uphold the standards

and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute. The panel also found you to have acted dishonestly and was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel therefore concluded that limbs a, b, c and d of the Grant test are engaged in respect of your conduct.

In respect of your dishonest conduct, the panel noted that the NMC Guidance set out that dishonesty was generally difficult to address. The panel noted that your dishonest conduct included failing to document the conduct described in charges 1c), 1d), 1e) and 1f). It noted that you mislead the local investigation into your behaviour by attempting to conceal your own and/or your colleague's actions towards Patient A. The panel noted that your dishonest behaviour led management to report Patient A to the police. She therefore faced the risk of a criminal investigation. At the time Patient A had been admitted to the ward 'following several serious suicide attempts.' This was as noted above, her first admission to a psychiatric unit.

As mentioned earlier, the panel was of the view that you attempted to mislead them during your oral evidence with respect to suggesting to the panel that Ms Perera knew about the plan for restraint when she did not. This suggestion was never made to Ms Perera during cross-examination.

Having considered these factors, the panel decided that your dishonest conduct breached a professional duty of candour and would be difficult to remediate as it amounts to serious misconduct and demonstrates deep-seated attitudinal concerns.

The panel then went on to consider whether the remaining charges found proved have been addressed and remediated. The panel took into account your oral evidence, Patient A's, Ms Perera's and Mr Russell's oral evidence, your reflective account, your training certificates and your curriculum vitae.

Regarding insight, the panel considered your written reflective piece and determined that you have not yet demonstrated any insight into the impact of your behaviour on patients, colleagues, the nursing profession and the wider public. In your written piece you spoke about how a Registered Mental Health Nurse should conduct themselves and the standards of practice that they should adhere to, and you also said that it was '*a significant learning experience for you*.' However, you did not admit any of the charges or explain specifically how you would apply this in your future practice. It further noted that you have not shown any remorse or apologised for your actions. The panel considered that your journey of remediation requires you to step back more fully and consider the misconduct found proved. As this has not occurred, the panel determined that there was no evidence of insight.

Whilst the panel recognised that you have undertaken some relevant training courses since the incident took place in 2023, it noted that many of these training courses were completed two days prior to the substantive hearing taking place. Furthermore, the panel noted that whilst you have engaged with the NMC throughout the proceedings, this is the expectation from a registered nurse. The panel further recognises that you have experienced difficulties in finding employment since the interim order was imposed and have not yet had an opportunity to demonstrate strengthened practice.

In light of this, the panel was not satisfied that your misconduct has been fully remediated. Accordingly, the panel determined that your misconduct is highly likely to be repeated.

The panel found that the findings of fact and the attitudinal concerns it had found proved meant that it could not be confident that your behaviour does not present a risk to wider public safety. The panel therefore concluded that a finding of impairment is necessary on the grounds of public protection, due to the serious nature of the charges.

The panel bore in mind that the overarching objectives of the NMC are 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 had regard to the serious nature of your misconduct and the public protection concerns it had identified. It determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case. A well-informed member of the public would be horrified to think a nurse caring for them had behaved in this manner. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on both public protection and public interest grounds.

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 the NMC guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

Submissions on sanction

Ms Jones submitted that the only appropriate and proportionate sanction in this case is a striking-off order.

Ms Jones submitted that there has been a significant period of time since the concerns arose. She acknowledged that the panel may consider that this period has provided you with sufficient opportunity to remediate your practice. She submitted that, despite undertaking training courses and completing a written reflective piece, you have not demonstrated any evidence of insight or remediation, and concerns regarding your clinical practice remain.

Ms Jones invited the panel to have regard to the principle of proportionality. She submitted that, given the seriousness of the facts found proved, together with your lack of insight, a striking-off order is the most appropriate and proportionate sanction.

Ms Jones identified the following aggravating factors:

- Patient A experienced physical and emotional harm due to your actions;
- There is no evidence that you have demonstrated any insight or shown remorse for your actions;
- Your conduct involved the abuse of a vulnerable patient.

In relation to mitigating factors, Ms Jones submitted that this was a single, isolated incident of misconduct, yet this incident was also serious in nature.

Ms Jones submitted that your conduct involved the violent abuse of a vulnerable patient. She submitted that the concerns are attitudinal in nature and are therefore not capable of remediation through training. She submitted that your behaviour demonstrated deep-seated attitudinal issues and that, as such, any sanction lower than a striking-off order would be insufficient. She further submitted that public confidence in the profession would be undermined if an appropriate sanction were not imposed. She submitted that there has been no explanation for what triggered your actions and submitted that there remains a risk of repetition.

Accordingly, Ms Jones invited the panel to impose a striking-off order.

Dr Akinoshun submitted that you continued to work as a nurse until the interim conditions of practice order was imposed in 2024. He submitted that you have attempted to comply with the interim conditions of practice order and invited the panel to consider that, in the absence of you finding suitable employment, there was little more that you could reasonably have done to comply with the conditions. He submitted that you have been open and transparent with all prospective employers regarding the conditions imposed upon your practice. He further submitted that, in the absence of employment, you have been unable to demonstrate development of your insight.

Dr Akinoshun submitted that the panel has found your fitness to practise impaired and referred the panel to the NMC Sanctions Guidance.

Dr Akinoshun submitted that the public would benefit from your continued practice, given your skills and knowledge as an experienced nurse of twenty-two years. He submitted that you have reflected on your actions and have strengthened your understanding of the importance of clear co-ordination and what you would do differently should a similar incident arise in the future. He further submitted that you have undertaken relevant training.

Dr Akinoshun submitted that, notwithstanding your denial of the charges, you have taken the opportunity to reflect upon them. He submitted that you have demonstrated a willingness to develop your insight and a determination to strengthen your practice.
Dr Akinoshun submitted that, since the imposition of the interim conditions of practice order, you have not been in employment but have undertaken relevant training to enhance your knowledge in relation to the concerns raised. He submitted that it is through no fault of your own that you have been unable to secure employment in order to comply with the interim conditions of practice order.

Dr Akinoshun submitted that between 19 September 2023 and 12 April 2024 you worked without any concerns being raised about your clinical practice following the incident. He submitted that you have acknowledged that further work is required in order to demonstrate full insight, in line with the panel's findings on misconduct and impairment. In relation to the principles of good practice, Dr Akinoshun submitted that you have kept your clinical knowledge up to date through the completion of relevant training, including PMVA training relevant to the charges.

In relation to mitigating factors, Dr Akinoshun referred to your oral evidence, in which you described how you maintained Patient A's airway during the incident by placing her on her side. He submitted that there is a need for nurses to protect patients and maintain public confidence in the profession, in accordance with the NMC Sanctions Guidance, and invited the panel to take this into account when determining the appropriate and proportionate sanction.

Dr Akinoshun submitted the following mitigating factors:

- You have fully engaged with the NMC throughout proceedings;
- There have been no previous concerns regarding your clinical practice, either prior to or since the incident;
- This was an isolated incident in your nursing career;
- You are an experienced nurse of over twenty-two years' standing with a previously unblemished regulatory record.

In relation to aggravating factors, Dr Akinoshun submitted that the panel has found that Patient A was put at risk of harm and that you have been unable to comply with the interim conditions of practice order due to difficulties in securing employment.

Dr Akinoshun submitted that a suspension order would be the appropriate and proportionate sanction. He submitted that a suspension order is appropriate where a nurse's conduct is serious but does not require permanent removal from the register. He

submitted that the seriousness of the concerns found proved warrants your temporary removal from the register in order to protect patients, maintain public confidence in the profession, and uphold professional standards.

Dr Akinoshun further submitted that this matter represents a single episode of misconduct in your twenty-two-year nursing career; that there is no evidence of deep-seated attitudinal concerns; that there has been no repetition of similar issues in your clinical practice since the incident occurred; and that the panel can be satisfied that you have demonstrated insight into your behaviour.

He invited the panel to impose a suspension order for a period of three to six months. He submitted that this would provide you with an opportunity to further develop your insight, demonstrate remorse, and continue your reflection, as well as to strengthen and develop your practice.

[PRIVATE].

[PRIVATE].

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating factors:

- Abuse of a position of trust as a Registered Mental Health Nurse in that you deliberately put people receiving care at risk of suffering harm: Patient A was receiving care under the mental health act and was put at risk of physical and emotion harm by your actions.
- Dishonesty in giving evidence: As already found by the panel as a matter of fact, it was of the view that you attempted to mislead them during your oral evidence with respect to suggesting to the panel that Ms Perera knew about the plan for restraint when she did not.
- Dishonesty found proved in relation to failing to document the conduct described in charges 1c), 1d), 1e) and 1f). The panel further noted that your dishonest behaviour led management to report Patient A to the police.
- Failure to work collaboratively with colleagues: The panel noted from the oral evidence of Ms Perera that she was not aware of the plan for restraint, which you had claimed in your oral evidence had been discussed with her and colleagues.
- Absence of insight: The panel has no evidence of insight or meaningful remediation.
- Vulnerability of the Patient receiving care: Patient A had been admitted to the ward ‘following several serious suicide attempts’ and this was her first admission to a psychiatric unit.

The panel took into account the following mitigating factors:

- Relevant training courses: The panel noted that you have completed some relevant training courses but have no evidence that you have demonstrated any remediation in relation to these training courses.
- Engagement with proceedings: The panel noted that you have engaged with NMC proceedings.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues

identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that your actions were not at the lower end of the spectrum, with serious charges found proved including the slapping of Patient A, causing significant injuries, acts of dishonesty, permitting colleagues to hold Patient A by the neck, throwing liquid over Patient A, and holding her head whilst she was in a prone position in her bedroom. In light of the seriousness of your misconduct and the public protection issues identified, the panel determined that a sanction that does not restrict your practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place conditions of practice on your registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026).

The panel considered that the charges found proved were serious in nature, including charges related to dishonesty. The panel noted that not only were you dishonest in your actions, that you were unnecessarily dishonest in your evidence by stating that you had discussed the plan for restraint with Ms Perera when you had not. The panel noted that

the NMC Guidance set out that dishonesty was generally difficult to address. As referred to in the impairment decision, the panel noted that whilst you have undertaken some relevant training courses, it noted that some of these training courses were completed two days prior to the hearing taking place and it has no evidence before it that you have demonstrated remediation in relation to these training courses.

The panel further noted that your written reflective piece demonstrated no evidence of insight into the impact of your actions on Patient A, colleagues, the nursing profession and the wider public, nor how your practice has been remediated since the incident took place. The panel determined that you have not demonstrated any evidence that you have remorse for your actions, have developed insight or have taken steps to remediate your conduct.

The panel determined that your dishonesty indicates that you have serious attitudinal issues. It considered that given the charges found proved relating to dishonesty and your lack of insight into your misconduct, that these attitudinal issues are likely to be deep-seated in nature.

The panel considered whether it would be possible to formulate relevant, proportionate, workable or measurable conditions that would protect patients and to uphold professional standards. Having regard to the nature and seriousness of your conduct, which includes deep-seated attitudinal issues, the panel concluded that it would not be possible to formulate such conditions.

The panel noted that you were previously under an interim conditions of practice order and whilst it was sympathetic that you have experienced difficulties in finding employment, it rejected the submission from Dr Akinoshun on your behalf, that you have been unable to demonstrate insight due to the conditions imposed, as insight is not gained from clinical practice alone. Furthermore, the panel noted that you have since retired from nursing and did not have confidence that any such order would be complied with in any event, given that you were unable to comply with the interim conditions of practice order. The panel

therefore concluded that a conditions of practice order would not be appropriate to protect the public or meet the public interest in this case.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional;*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all;*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation;*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions;*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time;*

- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel considered that a suspension order would protect the public for a period of time but in view of your lack of remorse, insight and remediation, a suspension order would not be sufficient to protect the public in the longer term, neither would suspension serve to uphold the public interest.

The panel rejected the submission from Dr Akinoshun on your behalf that a suspension order would achieve any remediation or insight. The panel noted that it has no evidence that in the two years and seven months since the incident took place, that you have made any attempt to demonstrate meaningful remediation. The panel therefore determined that there was no evidence before it that you would address your shortcomings over the course of a period of suspension. In view of the above and given the seriousness and nature of the facts found proved, the panel determined that a suspension order would not be sufficient to protect the public, uphold public confidence in the profession and maintain proper professional standards.

In reaching its decision, the panel considered the NMC's guidance in SAN-3 ('Deciding between suspension and strike off' – Last updated on 28 January 2026). It paid particular attention to the following paragraphs:

- *'Consider the professional's insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.*

- *Professionals are under an obligation to cooperate with their regulator. Where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight.'*

The panel recognised that whilst imposing a suspension order would give you an opportunity to address your behaviour and demonstrate insight, given your deep-seated attitudinal issues combined with a lack of remorse, evidence of insight, or remediation, including any positive work testimonials, the panel considered that there is no realistic prospect that you would address the concerns to such an extent that you would be able to return to unrestricted practice. The panel therefore concluded that a suspension order would not be a sufficient, appropriate or proportionate sanction.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *'Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?'*

The panel considered that your misconduct was serious in nature and involves concerns related to dishonesty, which raises fundamental questions about your professionalism. The panel noted that in particular, this includes deep-seated attitudinal issues. It therefore

determined that public confidence in the profession could not be maintained if you were permitted to remain on the register, particularly in view of your lack of meaningful remediation.

The panel considered that your actions represented significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register.

The panel determined that when dishonesty is found, there is an extremely high bar to pass in terms of demonstrating sufficient remediation to keep members of the public safe, maintain public confidence in the profession, and uphold professional standards. It noted that your misconduct involved dishonesty and caused Patient A serious physical and emotional harm. It determined that whilst full insight could, in principle, be achieved to protect the public and uphold professional standards, in light of the above, it did not consider this to be a realistic prospect. The panel concluded that your conduct was so serious that permitting you to continue practising would fail to protect the public and would undermine public confidence in the profession and in the NMC as a regulator.

In balancing all of these factors and taking into account all the evidence before it, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this 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.

Submissions on interim order

The panel took account of the submissions made by Ms Jones. She invited the panel to impose an interim suspension order for a period of 18 months on the grounds of public protection and in the public interest. She submitted that as the striking-off order will not take effect until after the 28-day period or until an appeal is disposed of or withdrawn, an interim order is necessary and proportionate to cover this intervening period to protect the public and meet the public interest in light of the serious concerns found.

Dr Akinoshun did not oppose the application.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

Being consistent with the findings, 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 determined that the charges found proved are so serious that they warrant a striking-off order, therefore you should be restricted from practice during the appeal period.

The panel has therefore imposed an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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.