

**Nursing and Midwifery Council  
Fitness to Practise Committee**

**Substantive Hearing  
Monday 3 November – Friday 7 November 2025  
Thursday, 2 April 2026**

Virtual Hearing

**Name of Registrant:** Twinkle Antwi Baffour

**NMC PIN:** 04L0755O

**Part(s) of the register:** Registered Adult Nurse – Sub part 1 (30 December 2004)  
Registered Mental Health Nurse – Level 1 (22 February 2007)

**Relevant Location:** Harrow

**Type of case:** Misconduct

**Panel members:** Richard Weydert-Jacquard (Chair, Registrant member)  
Melanie Lumbers (Registrant member)  
Margaret Stoddart (Lay member)

**Legal Assessor:** Angus Macpherson (3 – 7 November 2025)  
John Donnelly (2 April 2026)

**Hearings Coordinator:** Emma Hotston

**Nursing and Midwifery Council:** Represented by Alex Radley, Case Presenter

**Mr Baffour:** Not present and unrepresented

**Facts proved:** Charges 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13a), 13b), 13c)

**Facts not proved:** Charge 10

**Fitness to practise:** Impaired

**Sanction:** **Striking-off order**

**Interim order:**

**Interim suspension order (18 months)**

## **Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mr Baffour was not in attendance and that the Notice of Hearing letter had been sent to Mr Baffour's registered email address by secure email on 3 October 2025.

Mr Radley, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). He further submitted that an email was sent to Mr Baffour on 30 October 2025 informing him that the hearing had changed from being a physical to a virtual hearing, starting on 3 November 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing and the subsequent email dated 30 October 2025 provided details of the allegation, the time, dates and that the hearing was to be held virtually, and, amongst other things, information about Mr Baffour's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence. At the start of the hearing, Mr Baffour was sent an additional email stating that the hearing had begun and if he wished to join, joining details would be sent to him.

In the light of all of the information available, the panel was satisfied that Mr Baffour has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

## **Decision and reasons on proceeding in the absence of Mr Baffour**

The panel next considered whether it should proceed in the absence of Mr Baffour. It had regard to Rule 21 and heard the submissions of Mr Radley who invited the panel to continue in the absence of Mr Baffour. He submitted that Mr Baffour had voluntarily absented himself.

Mr Radley submitted that there had been no engagement in recent terms by Mr Baffour with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel decided to proceed in the absence of Mr Baffour. In reaching this decision, the panel considered the submissions of Mr Radley and the advice of the legal assessor. It paid particular regard to the factors set out in the decision of *R v Jones and General Medical Council v Adeogba* [2016] EWCA Civ 162 and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Baffour;
- Mr Baffour has not engaged with the NMC since 2021 and has not responded to any of the letters sent to him about this hearing;
- Mr Baffour has not provided the NMC with details of how he may be contacted other than his registered address;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- One witness is due to attend today to give live evidence, three others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020 and 2021;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Baffour in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, he has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence

on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, any limited disadvantage is a consequence of Mr Baffour's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

### **Details of charge**

That you a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

- 1) On one or more occasions fell asleep whilst on duty and/or in front of patients.
- 2) After being woken up by Colleague Z, responded using words to the effect of '*What, I'm tired.*'
- 3) Between 03:30 – 05:06, did not undertake patient observations for one or more patients as required.
- 4) On one or more occasions inaccurately recorded that you had undertaken observations for one or more patients between 03:30 – 05:06, as set out in schedule 1.
- 5) Your actions in charge 4) above were dishonest in that you falsified medical records, to conceal your failure to carry out observations for one or more patients as required.

- 6) Failed to complete the shift planner/rota in an adequate manner.
- 7) Inappropriately left the door to the ward open on one or more occasions.
- 8) Inappropriately left your shift after handover, without completing a drug count with one other nurse.
- 9) Administered Lorazepam during your shift without recording the administration.
- 10) Administered medication to one or more patients without signing the relevant drug to record the administration.
- 11) Inappropriately copied and pasted one or more entries from the SCO report completed on 31 May 2021 into the SCO report completed on 1 June 2021.
- 12) Your actions in charge 11) above were dishonest in that you falsified entries in the SCO report to misrepresent that you had completed accurate summaries of the shift.

That you a registered nurse, whilst working at Home B on 16 October 2020 at around 04:00;

- 13) Fell asleep in a chair whilst on duty, in that;
  - a) You had the light turned off;
  - b) Your eyes were closed;
  - c) You had taken your shoes off.

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

## **Decision and reasons on application to amend the charge**

The panel informed Mr Radley on behalf of the NMC, that it wished to amend the wording of charge 10, pursuant to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules), as follows:

*'10) Administered medication to one or more patients without signing the relevant drug **card** to record the administration.'*

The purpose of the amendment was to correct a grammatical error by inserting the word 'card,' to make sense of the allegation.

Mr Radley was content that the amendment could be made without injustice.

The panel accepted the advice of the legal assessor.

The panel determined to amend charge 10 as set out above. It was of the view that the amendment was in the interest of justice and was satisfied that there would be no prejudice to Mr Baffour. It was therefore appropriate to make the amendment, to correct the grammatical error.

## **Background**

Mr Baffour was first referred to the Nursing and Midwifery Council ('the NMC') on 3 March 2021 by [PRIVATE], his former employer. This referral resulted in an investigation by the NMC, which identified the regulatory concerns set out below.

The regulatory concern is:

1. Failure to ensure the safety of service users by sleeping whilst on duty during a night shift.

This regulatory concern relates to an incident that is said to have taken place on the night shift of 16 October 2020, whilst he was working at [PRIVATE] ('Home B') as a staff nurse.

The second referral in relation to this matter is in relation to Mr Baffour's employment at Home A, where he joined as a Senior Nurse in April 2021. He was referred to the NMC on 14 June 2021 by [PRIVATE].

The regulatory concern relates to an incident during a night shift on 1-2 June 2021, which occurred whilst Mr Baffour was working at Home A as a senior nurse in charge of the premises. During the night shift, members of staff observed Mr Baffour sleeping during the shift and he was reported to have spent a significant part of the shift in a telephone room and failed to carry out patient observations when he was required to do so. It is alleged that although he did carry out some observations later in the shift, he recorded the times inaccurately, providing a misleading impression that the observations were carried out on time. On this shift, Mr Baffour administered medication for some patients but failed to sign the medication cards to reflect that the administration of the medication had taken place. He also copied and pasted entries from the previous Shift Coordination Officers' (SCO) report onto the current SCO report, rather than completing his own observations.

### **Decision and reasons on facts**

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

The panel has drawn no adverse inference from the non-attendance of Mr Baffour.

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: Held the role of Healthcare Assistant (HCA) at Home A at the material time.
- Witness 2: Held the role of Director of Clinical Services at Home A at the material time.
- Witness 3: Held the role of Healthcare Assistant (HCA) at Home A at the material time.
- Witness 4: Held the role of Clinical Nurse Manager at Home B at the material time.

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 Mr Baffour.

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

### **Charge 1**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

- 1) On one or more occasions fell asleep whilst on duty and/or in front of patients.”

**This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; documentary evidence, including the Probationary Meeting Notes with Mr Baffour.

The panel heard oral evidence from Witness 1 that she found Mr Baffour in the upstairs lounge with patients present; his eyes were closed and he appeared to be asleep. Witness 1 explained that when she spoke to Mr Baffour, he opened his eyes and responded in an annoyed manner, saying 'What?'. The panel noted that Witness 1's oral evidence was consistent with their written statement, which stated the following:

*'I was working on a nightshift on 1-2 June 2021, along with Mr Baffour, who was the nurse in charge of the shift. At some point during the shift, I was in the office filling out the observations folder. I looked over to the lounge and saw that Mr Baffour appeared to be asleep on a couch in front of some of the patients. I approached Mr Baffour. He was sitting in an armchair, and had his eyes closed the whole time I was looking at him (probably about 10-15 seconds in total, though I don't know how long his eyes had been closed before I noticed him). I woke him up. He turned to me and said, 'What?', sounding annoyed. I said he shouldn't be sleeping in the lounge at work, especially not in front of patients. He went downstairs.'* [sic]

The panel further considered Witness 1's oral and written evidence to be consistent with their contemporaneous email, which was sent the day after the incident occurred and stated that Mr Baffour appeared to be asleep in front of patients. The email stated:

*'In the upstairs lounge whilst a patient was sat talking to him, he fell asleep. I saw this and went out and woke him up and he responded by saying "What, I'm tired?" And then got up and went downstairs. I understand this happened a second time in the downstairs lounge but I wasn't a witness to this one.'* [sic]

The panel also heard evidence from Witness 3 that Mr Baffour was asleep in the downstairs lounge and in the telephone room. CCTV footage was also seen showing Mr Baffour exiting the small telephone room after a period of time.

The panel was also shown CCTV footage by Witness 2, which showed Witness 3 carrying out the observations allocated to Mr Baffour at the material time. The panel noted that this CCTV footage supported the oral and written evidence provided by Witness 3.

In their oral evidence, Witness 3 described finding Mr Baffour in the service users' phone room, seated in a chair with his head back and eyes closed, appearing to be asleep whilst on duty. Witness 3 in their written statement also stated that they had found Mr Baffour asleep in the upstairs lounge on a separate occasion. Witness 3's oral evidence was consistent with their written witness statement and aligned with the evidence provided by Witnesses 1 and 2, in relation to the incident.

The panel noted in the Probationary Meeting Notes that he denied that he had been asleep whilst on duty and/or in front of patients. However, the panel preferred the evidence of Witnesses 1, 2 and 3, as their accounts were clear and consistent under examination with their oral evidence, written witness statements, and contemporaneous documentary evidence.

On the balance of probabilities, the panel determined that it was more likely than not that Mr Baffour fell asleep whilst on duty on more than one occasion, and that on at least one of those occasions, this occurred in areas in front of patients. The panel therefore found Charge 1 proved.

## **Charge 2**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

2) After being woken up by Colleague Z, responded using words to the effect of *'What, I'm tired.'*

### **This charge is found proved.**

In reaching this decision, the panel considered Witness 1's oral and written evidence, in addition to Mr Baffour's Probationary Meeting notes from 9 June 2021, provided by Witness 2, and the contemporaneous email sent by Witness 1, the day following the incident. The email sent by Witness 1 stated the following:

*'In the upstairs lounge whilst a patient was sat talking to him, he fell asleep. I saw this and went out and woke him up and he responded by saying "What, I'm tired?" And then got up and went downstairs. I understand this happened a second time in the downstairs lounge but I wasn't a witness to this one.'* [sic]

The panel noted that there was a slight discrepancy between the email and Witness 1's oral testimony and written witness statement, with regard to Mr Baffour's response to being woken up, where in their oral and written statement Witness 1 stated that Mr Baffour said 'What?,' whilst in the email sent by Witness 1, they stated that he said 'What, I'm tired.' When questioned by the panel about this discrepancy, Witness 1 stated that as the email was sent the day following the incident, that it was more likely to have been an accurate record of events than her memory when giving oral evidence at the time of the hearing. The panel accepted this explanation and noted that Witness 1 relied on their contemporaneous email sent the day after the incident, as being accurate. The panel also noted that slight inconsistencies in Witness 1's oral evidence was to be expected, given that it has been four years since the incident took place.

The panel noted in the documentary evidence of the Probationary Meeting notes, that although Mr Baffour denied being asleep whilst on duty, he accepted that he had been tired, as he could not sleep when he got home and was exhausted because he got home late due to transport on a bank holiday. The panel considered that this evidence provided context for Mr Baffour being tired whilst on shift, and it was consistent with the wording recorded in Witness 1's contemporaneous email.

The panel found Witness 1 to be a credible witness due to the consistencies in their oral and written evidence, and it considered their contemporaneous email to carry significant evidential weight. On the balance of probabilities, the panel was satisfied that Mr Baffour responded with words to the effect of *"What, I'm tired"* after being

woken up by Colleague Z (Witness 1). The panel found Charge 2 proved on this basis.

### **Charge 3**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

3) Between 03:30 – 05:06, did not undertake patient observations for one or more patients as required.”

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; and documentary evidence of the Observation and Engagement Record, Probationary Meeting Notes, emails and viewed CCTV, provided by Witness 2.

The panel heard evidence that Mr Baffour was the only registered nurse on duty during the night shift on which the incident occurred, where he allocated himself the responsibility for completing patient observations during the period from 03:30 to 05:06. The panel noted from the oral and written evidence provided by Witnesses 1, 2 and 3 that the allocation of roles for the shift on the allocation rota clearly identified that Mr Baffour was required to carry out these observations. The panel considered that, as the only registered nurse on duty, he was responsible and accountable for ensuring that these observations were undertaken and as a registered nurse, should have understood his role in carrying them out, specifically the clinical requirement for why these observations needed to be completed to ensure patient safety.

The panel noted that Witness 1 was consistent across their oral and written evidence in stating that Mr Baffour did not complete the required observations during the night shift between 03:30 and 05:06, and that another member of staff completed them on his behalf. The panel noted that Witness 1 in her written witness statement stated:

*'Mr Baffour didn't complete observations at the time when he was expected to complete this. Another member of staff completed observations instead of him.'*  
[sic]

The panel also noted the documentary evidence of an email sent by Witness 1 to Witness 2, which stated that Mr Baffour had not completed the observations that had been allocated to him. The email stated:

*'He was supposed to be on obs but was found in the quiet room downstairs, he came out but still didn't do the obs, luckily another staff member realised and continued to the obs in his absence.'* [sic]

The panel noted that Witness 1 was consistent between their written statement, oral evidence and documentary evidence. The panel also considered the explanation provided by Witness 1 in their oral evidence that these observations were required to be completed at set intervals of either one hour, or four times per hour, to ensure patient safety.

The panel also heard oral evidence from Witness 2, who stated that the observations completed during this time period were not carried out by Mr Baffour, and that another member of staff, Witness 3, completed the observations instead. Witness 2 explained that observations on this ward were required either hourly or four times per hour depending on the individual patient risk. The panel noted that the oral evidence provided by Witness 2 was consistent with their written witness statement, which stated:

*'When I arrived at work on the morning of 2 June 2021, some of the healthcare assistants approached me to let me know what had occurred on the night shift. I produce as Exhibit JM/1 email statements from healthcare assistants Witness 3, Witness 1 & Colleague A, outlining their concerns. Mr Baffour hadn't carried out observations of the patients. I believe we had around a dozen patients at the time. One of these patients Patient A, was prescribed Level 2 x 4 observations, which means the patient has to be observed four times within the hour due to being diagnosed with a life limiting condition. Mr Baffour was allocated to do observations for some patients, including Patient A, at a specific time of the night. Instead of carrying out these observations when they were required.'*

...

*Mr Baffour was expected to carry out observations on time, in line with our policy. As the nurse in charge of the shift and the only nurse working on this shift, he was also expected to stay awake for the duration of the shift. Mr Baffour's failure to carry out observations, as well as his being asleep on shift, involved clinical risks for the patients.' [sic]*

The panel noted in their oral and written evidence that Witness 2 explained that undertaking observations was a measure to protect patient safety as the ward was a forensic low secure unit and could be a high-risk environment. In particular, Witness 2 referred to that Patient A, who had a life-limiting condition and therefore required frequent monitoring of four times per hour. The panel noted that Witness 2 explained that these observations were an essential safeguard required for monitoring patients on the ward and needed to be completed in a timely manner to enable clinical staff to respond promptly to any deterioration. Witness 2 also stated in their oral evidence that observations could be completed by registered nurses, in addition to HCAs, and staff would have been allocated tasks throughout a nightshift on the allocation rota, to ensure that no observations were missed. Witness 2 stated that Witness 3, a HCA, completed the observations during the time period in question, as she had not seen that Mr Baffour had completed them.

Furthermore, the panel considered the documentary evidence of the Observation and Engagement Record. This showed that Mr Baffour accepted and signed a handover given to him and signed by Witness 3 at 03:28, to complete the observations, thereby demonstrating his acknowledgement of his responsibility to complete the observations.

The panel also noted that Witness 3 stated in their oral evidence that they undertook the observations on behalf of Mr Baffour during the hours of 03:30 and 05:06, as they had not seen him completing the observations during this time period. The panel noted that this evidence was supported by the documentary evidence of an email sent the day following the incident from Witness 3 to Witness 1, which stated:

*'He's allocated the observations from 03.30 – 05.30 however when I handed them over at 03.30 and informed him when the next observations would be he sat until 03.50ish and then said 'I'm tired, I'm going to rest' and then went to*

*sleep in the phone room – I wasn't sure what he was doing until 04.10ish when I realised he hadn't completed any observations so I quickly ran around the building to do some checks, returned downstairs and he walked from the phone room to the office and still didn't complete these. I asked him if he'd done them and he said yes. I haven't documented my observations in the folder however it can be evidenced on camera that I have checked the patients required.' [sic]*

The panel noted from the documentary evidence and oral evidence provided by Witness 3, that both Mr Baffour and Witness 3 had commenced employment at the same time in April 2021 and received the same induction training. The panel did not accept Mr Baffour's explanation in the documentary evidence of the Probationary Meeting Notes that he had problems with understanding the observation and engagement policy, where he stated that '*...all establishments have their own policies and procedures and new starters need to learn...*', as Witness 3, a HCA, demonstrated a clear understanding of the observation requirements. The panel noted that Mr Baffour was also an experienced registered nurse and should have been aware of the clinical need to complete observations in a timely manner.

The panel was satisfied that the oral and written evidence given by Witnesses 1, 2 and 3 was consistent, credible and supported by contemporaneous documentary evidence that demonstrated the need for the observations to be completed either hourly or four times per hour. On the balance of probabilities, the panel found it more likely than not, that Mr Baffour did not undertake the required patient observations for one or more patients between 03:30 and 05:06. The panel therefore found Charge 3 proved.

#### **Charge 4**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

4) On one or more occasions inaccurately recorded that you had undertaken observations for one or more patients between 03:30 – 05:06, as set out in schedule 1.”

**This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 2 and 3; and documentary evidence of the Observation and Engagement Record, Probationary Meeting Notes and CCTV footage, provided by Witness 2.

The panel heard oral evidence from Witness 2, who described reviewing the Observation and Engagement Record and noted that entries had been made by Mr Baffour for observations during the time period between 03:30 and 05:06, yet she had been informed by staff working on the night shift with Mr Baffour that he did not complete the observations during this time period, despite having documented that he had done so. This evidence was supported by the witness statement provided by Witness 2, which stated:

*‘When I arrived at work on the morning of 2 June 2021, some of the healthcare assistants approached me to let me know what had occurred on the night shift. I produce as Exhibit JM/1 email statements from healthcare assistants Witness 3, Witness 1 & Colleague A, outlining their concerns. Mr Baffour hadn’t carried out observations of the patients. I believe we had around a dozen patients at the time. One of these patients (“Patient A”) was prescribed Level 2 x 4 observations, which means the patient has to be observed four times within the hour due to being diagnosed with a life limiting condition. Mr Baffour was allocated to do observations for some patients, including Patient A, at a specific time of the night. Instead of carrying out these observations when they were required, Mr Baffour left the clipboard in the office and took himself to the telephone room, where he slept for a few hours. Witness 3 carried out observations for instead, just to ensure that they were safe, but she didn’t record these, as this was Mr Baffour’s job. Mr Baffour came out of the telephone room at around 5am, and recorded observations for the first time during that shift. However, he recorded random times on the observation*

*records. I believe he did so to make it look as though he had done these earlier in the night. I produce as Exhibit JM/2 copies of the relevant observation records. The highlighted sections are the observations that Mr Baffour documented that he had completed, with inaccurate times recorded.*

*Mr Baffour was expected to carry out observations on time, in line with our policy. As the nurse in charge of the shift and the only nurse working on this shift, he was also expected to stay awake for the duration of the shift. Mr Baffour's failure to carry out observations, as well as his being asleep on shift, involved clinical risks for the patients. If a patient's health had deteriorated quickly, then Mr Baffour would have been needed to make the necessary observations and escalate as needed. Mr Baffour was responsible for the whole shift, and he was needed for providing support to junior staff, which couldn't happen if he was asleep. The support staff on shift were very competent, and thankfully no emergencies occurred.' [sic]*

The panel noted that the CCTV footage shows, at the times listed in the CCTV footage summary in the documentary evidence, that Mr Baffour did not leave the telephone room to complete the required observations during the time period between 03:30 and 05:06. When he did leave the telephone room at 05:06, he was not seen carrying any files or a clipboard with him, which would have been required to complete the handwritten Observation and Engagement Record. The CCTV footage also showed another member of staff, Witness 3, undertaking observations of Patient A, during this period.

The panel considered the oral evidence from Witness 3, who had stated that they had carried out the observations on behalf of Mr Baffour because they had seen that he had not been completing the observations, even though the observations, including those of Patient A, had been allocated to him in the rota. Witness 3 stated that they did not document the observations, as this was Mr Baffour's responsibility to complete and their priority at the time of the incident was patient safety, rather than documentation. The panel noted that Witness 3's oral evidence was corroborated by the timeline shown on the CCTV footage, where Witness 3 is seen

completing the observations at the times that had been allocated to Mr Baffour in the rota.

The panel also noted that when Mr Baffour was first questioned by Witness 2 in the Probationary Meeting Notes, he initially denied failing to complete the allocated observations and stated that he had signed Patient A's Observation and Engagement Record at the times stated. However, when Witness 2 explained to Mr Baffour that they had reviewed the CCTV footage from the times he had signed from 03:42 to 05:17, they had noted that he had not checked on Patient A until 05:05. Mr Baffour then admitted that he had not completed the observations that he had recorded and had therefore falsified the documentation.

Having considered this evidence, on the balance of probabilities, the panel determined that it was more likely than not, that on one or more occasions, Mr Baffour inaccurately recorded that he had undertaken observations for one or more patients between 03:30 to 05:06. The panel therefore found Charge 4 proved.

### **Charge 5**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

5) Your actions in charge 4) above were dishonest in that you falsified medical records, to conceal your failure to carry out observations for one or more patients as required.”

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 2 and 3; and documentary evidence of the Observation and Engagement Record, Probationary Meeting Notes and CCTV footage, provided by Witness 2.

The panel reminded itself that it had already found Charge 4 proved, namely that Mr Baffour had recorded observations as having been completed when he had not in

fact undertaken these observations. The panel therefore went on to consider whether, in doing so, his actions were dishonest.

In determining this, the panel accepted the evidence of Witnesses 2 and 3 that Mr Baffour was aware of the observation requirements as an experienced registered nurse, and having completed the same induction and training as Witness 3. The panel noted that Mr Baffour was the only registered nurse on the night shift in relation to the charge and was therefore responsible and accountable for ensuring that observations were completed and accurately documented. The panel further noted that Witness 3, a HCA who started employment at Home A at the same time as Mr Baffour, clearly understood the clinical requirement to complete observations, which contradicted Mr Baffour's explanation in the Probationary Meeting Notes which stated:

*'Mr Baffour said he is still learning after 1 month – each establishment has their own policies and procedures and he has got to learn them here, he is sorry if they were not done, he then admitted that he had not done the checks.'*  
[sic]

The panel bore in mind Mr Baffour's response with reference to charge 4 and noted that he knew the observations had not been completed at the times recorded, yet he entered them into the Observation and Engagement Record, as though they had taken place. The panel also noted that Witness 3 was shown on the CCTV footage completing the observations that had been allocated to Mr Baffour, and this evidence was supported by documentary evidence and oral and written evidence from Witnesses 2 and 3, who were consistent across their accounts. The panel considered that Mr Baffour must therefore have known that the entries he had made into the Observation and Engagement Record were inaccurate and a falsification of medical records.

The panel then considered whether Mr Baffour's conduct would be regarded as dishonest by the objective standards of ordinary decent members of the public. The panel was satisfied that it would. The panel noted that accurate completion of documentation including observation records, is a fundamental role of the nursing profession, in order to ensure patient safety. The panel noted that the observation records were falsified, as they were also completed retrospectively, but had been

documented as if they had happened at the times that Mr Baffour had documented them to have taken place.

The panel therefore concluded that Mr Baffour falsified the medical records to conceal the fact that he had not completed the required observations for one or more patients, and that this was conduct that would be considered as dishonest by the objective standards of ordinary decent members of the public. The panel therefore found Charge 5 proved.

### **Charge 6**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

6) Failed to complete the shift planner/rota in an adequate manner.”

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; and documentary evidence of emails sent by Witnesses 1 and 3 to Witness 2.

The panel heard oral evidence from Witnesses 1, 2 and 3 that an allocation rota was required to be completed during each shift, and Witness 1 stated that it was usually completed in the first hour of the shift. The purpose of this rota was to ensure that all staff understood their allocated tasks throughout the shift, in addition to allocated breaks. The panel accepted the oral evidence of Witness 2 that completing the rota was a routine and necessary part of working on the ward, and that either the registered nurse on duty or a senior HCA would ordinarily undertake this task. The panel noted that, as the only registered nurse on duty on the relevant nightshift, Mr Baffour was expected to complete the rota.

This evidence was corroborated by the documentary contemporaneous email evidence sent by Witnesses 1 and 3 to Witness 2 following the relevant nightshift, with their concerns relating to Mr Baffour’s failure to complete the shift planner/rota in an adequate manner.

Witness 1 stated:

*'He was unable to do a rota, and it was around 10pm before he had finished and both times he did one, staff had to sort of agree amongst themselves what they were doing and when as the rota made no sense, despite staff offering to help him with it on multiple occasions.'* [sic]

Witness 3 stated:

*'It took him two hours to complete the shift planner and then myself and Colleague A had to redo it before printing as he'd put the 12-12 on for the full night shift, put himself on the planner twice, given people 3+ hour breaks etc.'* [sic]

The panel heard oral evidence from Witness 3, who stated that when Mr Baffour completed the rota, he assigned staff excessively long breaks, including breaks of up to three hours, and allocated staff to duties which extended beyond their allocated shift times. Witness 3 explained that the rota that Mr Baffour produced was unworkable and created a clinical risk because it left staff unsure of where they should be and the tasks they should be undertaking, and there were gaps where essential duties, including observations, were not covered. Witness 3 also stated that it would usually take less than one hour to complete the rota, whereas on this occasion, it took Mr Baffour over two hours and still left key tasks unallocated. The oral evidence from Witness 3 was supported by their written statement, which stated:

*'At the beginning of the nightshift, the nurse usually completes an allocation sheet which determines which staff hold which responsibilities in each area for certain time slots. I remember him being there for an unusually long time and offering if he needs help as the team were working on initiative and not from given orders, which at the time seemed unsafe to me as we were working on low numbers with lots of new/agency staff in a ward that I would say was quite unsettled with patients that regularly exhibited behaviours of concern and required intervention. Mr Baffour dismissed my offer of help yet eventually after around two hours did complete the allocation, which did not make sense at all. There were people who had been given 3+ hour breaks, some observations*

*were not covered, and some members of staff were not allocated to anything whilst some people were doubled up.' [sic]*

The panel determined that the evidence of Witnesses 1, 2, and 3 was consistent and credible across their oral and written accounts. It concluded that Mr Baffour was unable to complete the rota effectively and that the rota he produced could not be used to organise staff duties safely. The panel noted that the inadequately completed rota would have placed patients at risk of harm, as essential roles were not appropriately allocated and staff did not know their responsibilities for the shift. The panel was satisfied that Mr Baffour was aware of his responsibility to complete the rota as the only registered nurse on duty and accepted the evidence that he did not complete it to the required standard.

On the balance of probabilities, the panel found that it was more likely than not, that Mr Baffour had failed to complete the shift planner/rota in an adequate manner. It therefore found Charge 6 proved.

### **Charge 7**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

7) Inappropriately left the door to the ward open on one or more occasions.”

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3.

The panel heard oral evidence from Witness 2 who explained that the ward was a low secure forensic unit, and that it was important that all doors leading on and off the ward remained closed in order to maintain patient and staff safety. Witness 2 explained that the door onto the ward was key fob-controlled and that it was reported to her by Witness 3 that Mr Baffour left this door open several times. This evidence

was corroborated by Witness 3, who stated in her oral evidence that the doors to the ward were secure and required a key fob, she also explained that the doors did not close automatically and that they had to be closed manually. She stated in her contemporaneous email to Witness 2 that Mr Baffour had *'left the door to the ward open multiple times.'*

The panel also heard the oral evidence of Witness 1, who stated that on one occasion she personally witnessed Mr Baffour leaving the door open when he exited the ward. Witness 1 stated that they viewed this as a risk to patient safety and reported the incident. The panel noted that Witness 1's oral evidence was consistent with their written witness statement, which stated:

*'Mr Baffour also left the door to the ward open twice during the shift. No patients walked through the door and left the ward as far as I'm aware, but him leaving the door open created a risk of this happening.'*

The panel accepted the evidence from Witnesses 1, 2 and 3 that maintaining closed and securely locked doors was a fundamental safety measure on the ward, which was a low secure forensic unit. The panel also accepted that Mr Baffour was aware, through mandatory induction training and in his role as a registered nurse, of the need to ensure that the door to the ward remained closed.

On the balance of probabilities, the panel was satisfied that it was more likely than not, that Mr Baffour left the door to the ward open on more than one occasion and that this was inappropriate given the secure setting and the risks involved. Accordingly, the panel found Charge 7 proved.

### **Charge 8**

"That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

8) Inappropriately left your shift after handover, without completing a drug count with one other nurse."

**This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witness 2, in addition to documentary evidence, including the Drugs liable for misuse record and Probationary Meeting Notes.

The panel heard oral evidence from Witness 2 that it was a requirement at the start and at the end of each shift for both the nurse from the day shift and the night shift to check the drug count on the Drugs liable to misuse (and controlled drugs) record. Witness 2 explained that this process ensured that the Drugs liable for misuse record was accurate, and that any discrepancies were identified and addressed promptly. The panel accepted the evidence of Witness 2 that this was standard practice, and that Mr Baffour was aware of this requirement, having completed the induction training and through his experience as a registered nurse.

In her oral evidence, Witness 2 stated that on the relevant night shift Mr Baffour handed over the keys but did not complete the drug count with the nurse in charge taking over, before leaving. Witness 2 explained that Colleague B, the nurse in charge taking over, was present on the ward and was available to undertake the drug count with Mr Baffour. However, Mr Baffour left the shift without carrying this out. Witness 2's oral evidence was supported by their written witness statement, which stated:

*'Mr Baffour also left work straight after handover on 2 June 2021, instead of staying on to complete the drugs count with another nurse. As the nurse in charge of the shift and the only nurse working on this shift, he was expected to be available to assist with the drugs count.*

...

*I also spoke to Mr Baffour about him leaving the shift before assisting with the drug count. Mr Baffour said that the agency nurse he was supposed to be doing the drugs count with was late, and he couldn't wait around for them. I pointed out that Colleague B was there, and that Mr Baffour could have done the drug count with them. Mr Baffour said he didn't know they were there. My impression was that Mr Baffour knew he had to take part in the drug count, but just chose not to.' [sic]*

The panel noted that Witness 2's oral and written evidence was supported by the Drugs liable for misuse record, which demonstrated that Colleague B had completed the drug count and signed the record at 07:00 on 2 June 2021.

The panel considered the Probationary Meeting Notes, where Mr Baffour stated that he had not completed the drug stock count because the agency nurse, Colleague C, was late for their shift and he had not seen the nurse in charge, Colleague B. The panel did not accept this explanation, as the documentary evidence confirmed that Colleague B was in fact present on the ward, and had signed the drug count. Witness 2 also stated in her oral evidence that Mr Baffour ignored opportunities to engage with Colleague B to complete the task.

The panel considered that this matter constituted a failure by Mr Baffour to carry out a required and essential end-of-shift responsibility. The panel noted that the purpose of the drug count was to ensure the safe and accountable handling of medication.

On the balance of probabilities, the panel found it more likely than not that Mr Baffour inappropriately left the shift after handover without completing a drug count with one other nurse, and therefore, found Charge 8 proved.

### **Charge 9**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

9) Administered Lorazepam during your shift without recording the administration.”

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witness 2, in addition to documentary evidence, including the Drugs liable for misuse record, written statements provided by Colleagues B and C, and Probationary Meeting Notes.

The panel heard oral evidence from Witness 2 that, when the Drugs liable for misuse record was undertaken at the end of the shift on 1-2 June 2021, 2mg of Lorazepam was found to be missing. Witness 2 explained that a number of patients on the ward were prescribed Lorazepam and that any administration was required to be documented on the relevant drug chart at the time it was given. This evidence was supported by Witness 2's written witness statement, which stated:

*'As the nurse in charge of the shift and the only nurse working on this shift, he was expected to be available to assist with the drugs count. This was carried out by an agency nurse instead, and they found that 2mg of lorazepam was missing. I produce as Exhibit JM/3 a copy of the controlled drugs records showing this discrepancy. Lorazepam is given for agitation. Most of our patients were prescribed lorazepam as PRN, and some of them would ask for it when they felt discomfort. I don't believe that any theft of medication is likely to have occurred; I think it's more likely that one of the patients asked Mr Baffour for lorazepam and he gave this to them without documenting it. I produce as Exhibit JM/4 email statements from Charge Nurse Colleague B & Agency Nurse Colleague C outlining the concerns around the drugs count.*

...

*I spoke to him first about the missing drugs. Mr Baffour admitted that a patient had approached him to request 2mg of Lorazepam and that he hadn't recorded this in the book. I then mentioned that there were six patients with missing signatures from their drug cards. Mr Baffour also admitted to this, but downplayed this error, saying that it was common for nurses to not sign drug cards.'* [sic]

The panel noted that this evidence was supported by the written statements from Colleague B and Colleague C. Colleague B stated:

*'Agency staff nurse Colleague C approached me around 08:15 and informed me that there were discrepancies with Benzos; Lorazepam 2mg (2 tablets) and Zopiclone 7.5mg (1 tablet). I remembered outgoing nurse handing over that he had given a patient 7.5mg so we checked the patient's drug card and there*

*was a signature to evidence administration, hence missing Zopiclone was accounted for. We looked through all medication cards to check if anyone had been given lorazepam but we could not find evidence, we checked the Benzo register, two days back to see if there for calculation error and there was none. We also looked in the Disposal log just to check if it's been disposed of and staff forgot to adjust register. It was also discovered that there we missing signatures of night time medication. Docs were informed.'* [sic]

Colleague C stated:

*On entering the ward, Mr Baffour, the night staff nurse handed over the medication keys to me stating that he was late and he left. I went into the clinic room and started off by counting the Benzos and during the process I discovered that Zopiclone 7.5mg and Lorazepam 1mg tablets were short from the recorded balance, Zopiclone 7.5mg by one tablet and Lorazepam 1mg by 2 tablets. I then alerted NIC Colleague B and we counted the Benzos and checked the medication charts together in the hope that maybe the night staff nurse, Mr Baffour, had given the medication but missed to record them in the Benzo book. NIC Colleague B informed me that she remembered that, Mr Baffour, the night staff nurse had handed over that he had given a patient B 7.5mg of Zopiclone last night ( 01/06/21), however, this was not the case with 2mg of Lorazepam. In the end all other benzos were counted and were correct except 2mg of Lorazepam.'* [sic]

The panel noted that the Drugs liable for misuse record demonstrated the discrepancy in Lorazepam stock and showed that it had not been recorded in the disposal log, nor documented elsewhere. The panel found this supported the accounts from Witness 2, and Colleagues B and C, that the medication had been administered but not recorded.

Furthermore, the panel noted that Witness 2's oral and written evidence was supported by the contemporaneous documentary evidence in the Probationary Meeting Notes. This stated that when questioned about the discrepancy in the Drugs

liable for misuse record by Witness 2, Mr Baffour admitted that he had administered Lorazepam to a patient during the shift but had not recorded the administration.

The panel preferred the evidence of Witness 2, which it found to be credible and consistent across their written and oral evidence. The panel noted that accurate recording of medication administration is a fundamental nursing duty and that failure to document this creates a risk to patient safety, and medication audit processes.

On the balance of probabilities, the panel was satisfied that it was more likely than not that Mr Baffour had administered Lorazepam during the shift without recording the administration. It therefore found Charge 9 proved.

### **Charge 10**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

10) Administered medication to one or more patients without signing the relevant drug card to record the administration.”

### **This charge is found not proved.**

In reaching this decision, the panel took into account the written witness statement provided by Witness 2, in addition to documentary evidence, including the Probationary Meeting Notes.

The panel noted in the contemporaneous documentary evidence of the Probationary Meeting Notes that Mr Baffour commented that ‘we all do mistakes,’ when questioned by Witness 2 in relation to there being signature gaps in drugs cards for six patients. Furthermore, the panel noted that this evidence is corroborated by Witness 2’s written witness statement, which stated:

*‘I then mentioned that there were six patients with missing signatures from their drug cards. Mr Baffour also admitted to this, but downplayed this error, saying that it was common for nurses to not sign drug cards.’ [sic]*

The panel bore in mind the written evidence from Witness 2 and the evidence in the Probationary Meeting Notes that Mr Baffour appeared to admit that he had administered medication to one or more patients without signing the relevant drug card to record the administration. The panel noted however, that it had not received copies of the relevant drug charts, which would have strengthened the evidence on this particular charge. It also noted that no other contemporaneous documentary evidence relating to unsigned drug administration records had been provided, aside from the Probationary Meeting Notes and written statement from Witness 2, furthermore, the panel did not have any direct evidence from any witnesses that were present at the time to support this charge.

The panel decided on this basis that the NMC had not discharged its burden of proof and determined that the evidence presented was not sufficiently reliable or corroborated to establish, on the balance of probabilities, that Mr Baffour administered medication to one or more patients without signing the relevant drug card to record the administration. It therefore found Charge 10 not proved.

### **Charge 11**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

11) Inappropriately copied and pasted one or more entries from the SCO report completed on 31 May 2021 into the SCO report completed on 1 June 2021.”

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral and written evidence provided by Witnesses 1 and 2, in addition to documentary evidence, including contemporaneous emails.

The panel heard evidence from Witness 2 that the SCO report is used to communicate key information from one shift to the next, including relevant events, patient presentation, risks, and any changes in care needs. The panel accepted the

evidence of Witness 2, who explained that the SCO report is intended to provide an accurate and shift-specific record to support continuity of patient care and staff awareness of any ongoing concerns about any of the patients.

In her written statement and oral evidence Witness 2 stated that, when reviewing the SCO report completed by Mr Baffour on 1 June 2021, which was reported to her as being inaccurate by staff that had worked with Mr Baffour on the nightshift in relation to this charge, they noticed that the entries for the majority of the patients were broadly similar to those recorded in the SCO report from the previous night shift on 31 May 2021. Witness 2 explained that the most likely reason that the entries were the same in so many instances was that the entries for the majority of the patients had been copied and pasted, rather than updated to accurately reflect the events that occurred during Mr Baffour's shift.

Witness 2 confirmed in her oral evidence that the SCO report is kept open and editable throughout the shift, meaning it would have been possible to record events in real time. The panel noted that the fact that the majority of the entries were exactly the same as those from the night before and this indicated that Mr Baffour had not accurately completed the SCO report in real time throughout his shift. This evidence was supported by Witness 2's written statement, which stated:

*'Two of our care assistants raised concerns that Mr Baffour filled out the SCO report, which is our handover document, by copying and pasting previous entries made by other nurses. This was raised in Colleague A and Witness 1's emails, both of which are in Exhibit JM/1. I produce as Exhibit JM/5 copies of the SCO reports for 31 May 2021 and 1 June 2021. The SCO report for 1 June 2021 appears to be completely copied from the SCO report for 31 May 2021. The risks in simply copying and pasting information from an earlier SCO report are that staff wouldn't be given a true representation of the previous shift, including patient interactions, incidents, medication, diet and fluid issues etc. Staff need to have an accurate picture of the previous shift, as this can inform the actions they take for patients during their own shift.'*

The panel also heard evidence from Witness 1 who raised concerns that the SCO report appeared to contain information that was not reflective of the shift in question.

Their account was consistent with Witness 2's evidence and supported the conclusion that the report had not been completed accurately. Witness 1 stated:

*'The SCO report is made by the nurse in charge of a shift, and this is used for handover to the nurses on the following shift. I saw Mr Baffour's SCO report that he completed for this nightshift. It contained a lot of information which wasn't accurate, for example, he said that some patients had slept through the night when in fact they were up and about. I believe Mr Baffour didn't understand the importance of the SCO report and had just copied and pasted sections from the SCO report for the previous shift.'* [sic]

Furthermore, the panel noted that the evidence was further corroborated by the contemporaneous emails sent by Witness 1 and Colleague A, following the incident. Witness 1 stated:

*'The SCO report wasn't updated properly, I believe a lot of it was copied and pasted and so wasn't accurate, stating patients were asleep all night when they weren't and vice versa. I believe staff also helped him with this.'* [sic]

Colleague A stated:

*'I have just checked the SCO report which has been emailed out and have noticed that he has copied a lot of the information from the previous night, which isn't a true representation of the events which have taken place during tonight's shift.'* [sic]

The panel considered the evidence from all witnesses to be credible and consistent across their accounts and documentary evidence. It was satisfied that the SCO report completed by Mr Baffour on 1 June 2021 contained content that had been copied from the report completed on 31 May 2021, and that this did not accurately reflect the events of Mr Baffour's shift.

On the balance of probabilities, the panel found that it was more likely than not, that Mr Baffour inappropriately copied and pasted one or more entries from the report completed on 31 May 2021 into the SCO report completed on 1 June 2021, rather

than completing a new, accurate and contemporaneous record. The panel therefore found Charge 11 proved.

## **Charge 12**

“That you, a registered nurse, whilst working at Home A as the nurse in charge, on the night shift of 1/2 June 2021;

12) Your actions in charge 11) above were dishonest in that you falsified entries in the SCO report to misrepresent that you had completed accurate summaries of the shift.”

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral and written evidence provided by Witnesses 1 and 2, in addition to documentary evidence, including contemporaneous emails.

The panel reminded itself that it had already found Charge 11 proved, namely that Mr Baffour copied and pasted entries from the SCO report for 31 May 2021 into the SCO report he completed for 1 June 2021, rather than accurately recording the events that had occurred during his shift. The panel therefore went on to consider whether Mr Baffour’s actions in doing so were dishonest.

In determining this, the panel accepted the evidence that Mr Baffour had completed the same induction training as other staff, including Witness 3, and should have been aware that the SCO report was required to provide an accurate shift-specific handover. The panel noted that as an experienced registered nurse, Mr Baffour was expected to understand the importance of ensuring accurate documentation. The panel considered that Mr Baffour must have known that copying and pasting entries from the previous day would result in the SCO report containing inaccurate summaries of the shift.

The panel then considered whether Mr Baffour’s conduct would be regarded as dishonest by the objective standards of ordinary decent members of the public. The

panel was satisfied that it would. The panel noted from the oral and written evidence provided by Witness 2 that the SCO report was an ongoing live document used at handover to inform oncoming staff of patient risks and any changes in their condition. By completing the report inaccurately, the panel noted that this could lead to inappropriate care and potential harm to patients. The panel was satisfied that an ordinary decent member of the public would consider Mr Baffour's behaviour to be dishonest by presenting copied information, as if it accurately reflected events that occurred during his shift, particularly where the information was relied upon for patient safety.

The panel noted that due to the needs of patients on the low secure forensic unit, who might exhibit challenging or aggressive behaviour, that it would be crucial for accurate documentation to be made, in terms of assessing patients and communicating this to oncoming staff.

The panel considered that Mr Baffour must have known that his entries did not accurately reflect events from the shift in question and that his behaviour was dishonest in that he falsified entries in the SCO report to misrepresent that he had completed accurate summaries of the shift. On this basis, the panel concluded that Mr Baffour's actions were dishonest and accordingly, found Charge 12 proved.

### **Charge 13**

"That you, a registered nurse, whilst working at Home B on 16 October 2020 at around 04:00;

13) Fell asleep in a chair whilst on duty, in that;

- a) You had the light turned off;
- b) Your eyes were closed;
- c) You had taken your shoes off."

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and written evidence provided by Witness 4, in addition to documentary evidence, including the Incident log dated 28 October 2020, Investigation Report dated 28 October 2020, local investigation meeting notes dated 31 December 2020, and Mr Baffour's written statement.

The panel heard oral evidence from Witness 4, who stated that at approximately 04:00 she entered the lounge area accompanied by another staff member and found Mr Baffour slouched in a chair, with his shoes off and his eyes closed and the lights were off. Witness 4 explained that although the lights in the lounge were off, this was common practice during the night shift, as most patients were asleep. Witness 4 stated that Mr Baffour's posture and presentation led her to believe that he was asleep. Witness 4 also stated that she called Mr Baffour's name several times at a normal speaking volume before he eventually awoke.

The panel considered that Witness 4 was a credible witness; their account was consistent across their witness statement and oral evidence, and the documentary evidence provided in the Incident log dated 28 October 2020, Investigation Report dated 28 October 2020 and local investigation meeting notes dated 31 December 2020. The panel also noted that the local investigation meeting and the Incident log were documented a few weeks following the incident and provided contemporaneous evidence. In the Incident Log, Witness 4 stated:

*Performed an investigation with him and he has denied that he was asleep and he has said that he was resting as he was tired because he had had a busy day. He admitted that he left work on the Wednesday night went and bought a car and then was shopping round for places to get an engine, before he knew it, it was time to go home and get ready for work. He admitted he was tired. He stated that most of the staff were on their break and that is why he was in the lounge. However most of the staff were on the unit working.'*[sic]

The panel noted that this evidence was supported by the written witness statement of Witness 4, which stated:

*'On 16 October 2020, I attended [Home B] during a night shift to show our new*

*manager, Colleague D, around and introduce her to staff. We eventually arrived on the unit where Mr Baffour was working and came into a lounge, which had the lights off. As we walked in, we saw that Mr Baffour was sitting asleep in a chair. His eyes were closed and he had removed his shoes. I said his name a couple of times, to see if he would wake up. Mr Baffour didn't respond.*

*We stood there for the next 5-10 minutes, talking to each other at a normal volume. Mr Baffour didn't give any indication that he could hear us. After about 5-10 minutes, Mr Baffour opened his eyes and acknowledged us. We asked why he had been asleep, and he said he was just resting on his break. We said that he can't sleep during his break, and that we would speak to him later about this. Colleague D called Mr Baffour into her office later and told him that he would be invited to an investigation meeting. I produce as Exhibit GC/01 a copy of the incident log.' [sic]*

The panel noted from the oral and written evidence provided by Witness 4 that Mr Baffour did not respond for some ten to fifteen minutes after she and another staff member entered the room, had a discussion in a normal register, nor did Mr Baffour open his eyes or acknowledge them until prompted. The panel considered that a person who was resting with awareness of their surroundings would be likely to show some sign of acknowledgement when colleagues entered the room and therefore did not accept that he was not asleep at the material time.

The panel considered Mr Baffour's explanation in his written statement and in his response to Witness 4 in the local investigation meeting notes, that he denied being asleep and was resting because he was tired. He stated:

*'I wasn't sleeping. I closed my eyes because I was relaxing because I couldn't have a break, as I had a lot to do – But I was tired.'* [sic]

Furthermore, the panel noted the inconsistency in Mr Baffour's evidence in comparison with his written reflective account, which stated:

*'Two members of the management team met me sitting in the lounge at dawn around 0400 hrs with my shoes removed because of [PRIVATE]; listening to*

*BBC news on the TV and relaxing because I was tired from a medical emergency incident that had occurred earlier. I had put the legs on a small coffee table. I stood up and went to the nurses office. They did not tell me anything. Some days later I received an e-mail to attend a meeting with one of them. At the meeting I was told 'I was met sleeping.' I was shocked.' [sic]*

The panel preferred the evidence of Witness 4, which it found was credible and consistent across their oral and written accounts, and documentary evidence. The panel noted that as Mr Baffour kept his eyes closed, despite staff being in the same room, and he was slouching in the chair, this would suggest that he was asleep whilst on duty. It concluded, on the balance of probabilities, that it was more likely than not that Mr Baffour fell asleep on duty at the time in question, with his shoes removed and his eyes closed. The panel also considered from the oral evidence provided by Witness 4 that it was normal practice for the light to be turned off in the patient lounge at night. The panel therefore found Charge 13 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 Mr Baffour's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Baffour's 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.*’

Mr Radley invited the panel to take the view that the facts found proved, on all regulatory charges except for charge 10, amounted to misconduct. The panel had regard to the terms of ‘The Code: Professional standards of practice and behaviour for nurses and midwives 2015’ (the Code) in making its decision.

Mr Radley directed the panel to the guidance of Jackson J in *Calhaem v GMC* [2007] EWHC 2606 (Admin) and Collins J in *Nandi v GMC* [2004] EWHC2317 (Admin); which states that ‘[Misconduct] connotes a serious breach which indicates that the [Nurse’s] fitness to practice is impaired. The adjective ‘serious’ must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.’

Mr Radley submitted that Mr Baffour’s acts, or omissions, fell far short of the standards set out in the Code and that his actions amount to serious professional misconduct. He submitted that the actions reported and found proven are failings directly related to the care of patients and the management of patients who are vulnerable, specifically through mental health.

Mr Radley directed the panel to the NMC guidance, ‘How to determine seriousness’ Reference: FTP-2a, relating to concerns that are serious and more difficult to put right. He submitted that the relevant serious concerns relating to Mr Baffour are at the heart of a caring profession, including compassion, namely the manner in which he approached his duties; abrupt short replies, namely the language he used towards staff; and a lack of candour.

Mr Radley submitted that the panel will be aware that seriousness is an important concept which informs various stages of the regulatory processes. He invited the panel to find that each of the charges proved was sufficiently serious to amount to misconduct, due to Mr Baffour's lack of candour and dishonesty. He emphasised that Mr Baffour's behaviour represented a significant departure from the standards expected of a registered nurse, with direct consequences for the safety and wellbeing of vulnerable patients. He further submitted that the NMC case on misconduct relied upon the dishonesty of Mr Baffour, medication management issues, his relations with other staff and poor care of vulnerable patients.

Mr Radley submitted that it is important for the panel to consider evidence of any relevant contextual factors, however submitted that regrettably, there is no evidence to help the panel with what, if any, problems Mr Baffour had.

Mr Radley identified the specific, relevant standards of the Code where Mr Baffour's actions amounted to misconduct. These included: 1.1, 1.2, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, 2.6, 3.1, 3.3, 3.4, 4.1, 4.2, 4.3, 4.4, 5.2, 5.5, 6.1, 6.2, 7.1, 7.2, 7.3, 7.4, 8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, 9.2, 9.3, 10.1, 10.2, 10.3, 10.4, 11.1, 11.2, 13.1, 13.2, 13.3, 13.4, 14.1, 14.2, 14.3, 15.1, 15.2, 15.3, 16.1, 16.2, 16.3, 16.4, 16.5, 16.6, 17.1, 17.2, 17.3, 18.1, 18.2, 18.3, 18.4, 19.1, 19.2, 19.3, 19.4, 20.1, 20.2, 20.3, 20.5, 20.6, 20.8, 20.9, 23.3, 24.2, 25.1, 25.2.

Mr Radley invited the panel to pay attention to the period of time during which Mr Baffour's misconduct took place over, the potential serious outcome of the misconduct including the potential to cause harm to vulnerable mental health patients; the lack of professionalism in his behaviour towards other staff members; the failure to follow up incidents and displaying an un-caring and laissez-faire attitude towards patients; not completing observations and not knowing who the patients on the unit were; the lack of effective engagement with staff; the lack of legitimate documentation, notes and rationale for the decision, and his dishonesty.

Mr Radley submitted that these factors can have a serious effect on patient trust and confidence in the nursing profession, especially in the case of the vulnerable patients

being dealt with here. He submitted that this underpins the need to identify Mr Baffour's behaviour as serious misconduct.

### **Submissions on impairment**

Mr Radley highlighted that the next step for the panel to consider is whether Mr Baffour's fitness to practise is currently impaired. He referred the panel to the NMC Guidance on Impairment (DMA-1) and highlighted that the Guidance invites the panel to consider this question:

*'Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

Mr Radley submitted that the issue of impairment would involve a consideration of both the nature of the concern and 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).

Mr Radley submitted that Mr Baffour's misconduct engaged all four limbs (a) to (d) of the *Grant* test. He submitted that a decision about whether a professional's fitness to practise is impaired takes a holistic approach, so that anything that is relevant is considered. It is dependent on the individual circumstances surrounding each concern found by the panel. He referred the panel to the earlier concerns on the breaches of the Code contained within his submissions on misconduct. He submitted that Mr Baffour's breaches of the Code involved breaching a fundamental tenet of the profession.

Mr Radley submitted that a finding of impairment is required to mark the unacceptability of Mr Baffour's behaviour, to emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards or behaviour. He submitted that Mr Baffour has provided no evidence or involvement in the fitness to

practise process or engagement in this hearing. He further submitted that Mr Baffour has not provided evidence of a recent reflective piece; learning to address the charges; witness support; medical evidence allowing challenge; a portfolio evidence of training or evidence of the risks being addressed.

Mr Radley submitted that whether it is likely that Mr Baffour's conduct will be repeated is a concern for the NMC. This will impact on Mr Baffour's ability to practise kindly, safely, and professionally. He further submitted that Mr Baffour's misconduct risked patients' trust and confidence and is very serious in areas including the security of the unit, dishonesty and drug management.

On this basis, Mr Radley invited the panel to find that Mr Baffour's fitness to practise is impaired, both on the grounds of public protection and in the wider public interest.

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

## **Decision and reasons on misconduct**

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

The panel was of the view that Mr Baffour's actions did fall significantly short of the standards expected of a registered nurse, and that his 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***

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

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

*To achieve this, you must:*

**3.1** *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

**8 Work cooperatively**

*To achieve this, you must:*

**8.2** *maintain effective communication with colleagues*

**8.3** *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

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

**8.6** *share information to identify and reduce risk*

**10 Keep clear and accurate records relevant to your practice**  
***This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.***

*To achieve this, you must:*

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

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

**Preserve safety**

**13 Recognise and work within the limits of your competence**

*To achieve this, you must, as appropriate:*

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

*13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

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

*To achieve this, you must:*

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

***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***

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

The panel first considered whether the facts found proved amounted to misconduct. The panel noted that the shortcomings in Mr Baffour's practice occurred whilst he was the only registered nurse on night duty in care settings where the patients were highly vulnerable. The panel had heard evidence that the majority of the patients under Mr Baffour's care at Home A were detained under the Mental Health Act and presented a risk to themselves and/or others, furthermore Patient A had a life-limiting physical condition which required frequent and timely observations to ensure patient safety. Evidence was provided that the registered nurse on night duty had a paid break; they were not permitted to sleep during any part of their shift. The panel considered that as the only registered nurse on duty, Mr Baffour was required to exercise professional judgment, provide clinical leadership, and ensure that essential

observations, medication administration, and record keeping were carried out safely. His actions occurred on multiple occasions across two nightshifts and reflected repeated failures in fundamental aspects of nursing practice. The panel considered that Mr Baffour's actions therefore created a direct risk of harm to patients, both through failure to undertake essential observations, and through the falsification of medical records which were relied upon by other staff to provide safe and continuous care.

The panel identified the following themes within Mr Baffour's misconduct:

- Falling asleep whilst on duty and negligence in carrying out a duty of care
- Failings in clinical care and assessment
- Failures in medicines management
- Falsification of medical records

The panel noted that two additional charges fell outside of these themes but also involved conduct that posed a risk to patient safety: Charges 6 and 7.

The panel found that the following charges in particular amounted to misconduct:

### **Charges 1 and 2:**

The panel considered that by intentionally sleeping in both lounges and the telephone room during the night shift, and by failing to complete the scheduled observations for which he had rostered himself, Mr Baffour unjustifiably failed to carry out clear and essential patient care duties. Furthermore, he had turned his radio off and could not be contacted when needed. Consequently, colleagues had to divert their attention from patients in order to locate him. This was particularly serious given that he was the only registered nurse on duty and therefore carried full responsibility for maintaining observations and patient wellbeing, including the care of vulnerable patients with complex mental health needs and one patient with a life-limiting condition.

The panel determined that Mr Baffour's conduct failed to uphold the standards expected under the Code and as such, his conduct fell significantly short of the professional responsibilities required of a nurse. The panel further considered that if patients or members of the public were aware that he had fallen asleep on duty, confidence in the nursing profession would be undermined. The panel considered Mr Baffour's actions in this charge to amount to misconduct.

The panel noted that Mr Baffour's response when woken, as set out in Charge 2, was linked to the same behaviour and therefore also amounted to misconduct.

#### **Charges 3 and 4:**

The panel considered that the failure to undertake the required patient observations, and the subsequent inaccurate recording that they had been completed, represented a serious failure in basic nursing practice. Observations form an essential safeguard to detect deterioration or risk of harm. As the senior nurse on duty, he had rostered himself to undertake the observations and was responsible for ensuring that they were completed. Falsely recording that they had been done created a direct risk of harm and represented a serious departure from the standards of safe practice. This resulted in no accurate recording of patients' conditions throughout this allocated time period. As such, the panel determined that Charges 3 and 4 both amounted to misconduct.

#### **Charges 5 and 12:**

The panel considered whether dishonesty involving medical records amounts to misconduct. It noted that the falsification of medical records, including observations and the SCO report, undermines the accuracy of the clinical record, misleads colleagues, and compromises patient safety. It further noted that dishonesty in a clinical context represents a fundamental breach of trust placed in registered nurses by patients, colleagues, and the wider public. The panel therefore determined that the dishonesty in Charges 5 and 12 amounted to misconduct.

### **Charge 6:**

The panel noted that completing the shift rota was an essential nursing task required to organise staff roles. The panel heard evidence that it took Mr Baffour over two hours to complete a task that ordinarily took other staff 45 minutes, and furthermore, the rota he produced was unworkable, placing multiple staff on breaks at the same time and leaving essential duties uncovered. The panel noted that Mr Baffour also refused and dismissed offers of assistance with completing the rota and acted unprofessionally by not recognising his level of competency. In failing to recognise his lack of competence in being able to complete the rota in an adequate manner and in refusing assistance from other staff, the panel considered Mr Baffour's actions amounted to misconduct, particularly as it caused issues in delaying patient care and team coordination

### **Charge 7:**

The panel considered that leaving the door to a low-secure forensic unit open posed a clear and unacceptable risk to patient and staff safety. This breached a fundamental security requirement designed to prevent harm to patients detained under the Mental Health Act. The panel therefore found that Charge 7 amounted to misconduct.

### **Charges 8 and 9:**

The panel considered that the failure to complete the Drugs liable for misuse record at the end of the shift, and the failure to record the administration of Lorazepam, were serious departures from safe medicines management practice, putting patients and staff at risk of harm. The panel bore in mind that Mr Baffour's actions contravened local policy to complete stock checks at the start and end of each shift and created the potential for medication misuse or error. The panel also bore in mind that there was a later discrepancy identified by staff regarding the stock check for Lorazepam, which was listed under the Drugs liable for misuse record, which was not identified by Mr Baffour. Subsequent investigation found he had administered the missing Lorazepam to a patient without recording the administration of the drug.

The panel therefore concluded that Charges 8 and 9 amounted to misconduct.

### **Charge 11:**

The panel noted that it had heard evidence that the SCO report was relied upon by the incoming shift to understand patient risks and changes in presentation. By copying and pasting entries, the panel noted that the SCO report provided by Mr Baffour did not accurately reflect the care that had taken place that was witnessed by staff, failing to record any changes in the patients' conditions or behaviour. This created a misleading report for the staff taking over and put patients at unwarranted risk of harm, as they would not have been able to accurately identify patient deterioration at the earliest opportunity. The panel considered Mr Baffour's actions in this charge to be a clear departure from the expected professional standards of a nurse and therefore amounted to misconduct.

### **Charge 13:**

For the same reasons as Charges 1 and 2, the panel considered that falling asleep whilst on duty, especially as the only registered nurse, with a responsibility for highly vulnerable patients with dementia, represented a serious breach of Mr Baffour's professional duty as a nurse. The panel therefore concluded that Mr Baffour's actions amounted to misconduct.

### **Decision and reasons on impairment**

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

Registered 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 justifies both their patients' and the public's trust in the profession at all times.

The panel had regard to the NMC Guidance on Impairment (DMA-1) especially the question which states:

*'Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

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 Mr Baffour's past conduct. The panel was of the view that Mr Baffour's misconduct in relation to all of the facts found proved, put patients or other members of the public, at unwarranted risk of harm.

The panel found that this misconduct constituted a serious breach of the fundamental tenets of the nursing profession in that Mr Baffour failed to prioritise people, practise effectively, preserve safety and promote professionalism and trust. It determined that Mr Baffour 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 Mr Baffour to have acted dishonestly on more than one occasion.

The panel therefore concluded that limbs a, b, c and d of the Grant test are engaged in respect of Mr Baffour's past conduct.

The panel next considered whether the limbs of the *Grant* test are engaged as to the future. In this regard, the panel considered the case of *Cohen v GMC* in which the Court addressed the issue of impairment with regard to the following three considerations:

- a. Is the conduct that led to the charge easily remediable?*
- b. Has it in fact been remedied?*
- c. Is it highly unlikely to be repeated?'*

In this regard, the panel also considered the factors set out in the NMC guidance on Insight and strengthened practice (FTP-15).

The panel first considered whether Mr Baffour's misconduct is capable of being addressed. In the NMC guidance – Can the concern be addressed (FTP-15a), the panel noted the following paragraph:

*'In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.*

*Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*

- ....
- *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice*

*Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents.*

*Examples of such concerns include:*

- *medication administration errors*
- *poor record keeping*
- *failings in a discrete and easily identifiable area of clinical practice'*

In respect of Mr Baffour's dishonest conduct, the panel noted that the NMC guidance set out that dishonesty was generally difficult to address. The panel noted that Mr Baffour's dishonest conduct specifically related to his clinical practice whilst working

on a shift as the only registered nurse on duty and included falsification of observation charts and entries into the SCO report on more than one occasion without any clinical justification. Having considered these factors, the panel decided that Mr Baffour's dishonest conduct would be extremely difficult to remediate. Furthermore, the panel noted that this serious misconduct, which included dishonesty and a lack of remorse, insight, or evidence of strengthened practice in the four years since the concerns were raised, is indicative of a deep-seated attitudinal issue regarding Mr Baffour's professional accountability and the prioritisation of patient safety and wellbeing.

The panel considered Mr Baffour's dishonest conduct to fall within the moderate range of seriousness. It considered that it was not at the lower end, as it occurred in relation to Mr Baffour's clinical practice and put vulnerable patients at risk of harm. In their written witness statement, Witness 2 said:

*'...Giving medication without documenting that it has been given can have clinical risks, as it gives other nurses wrong information about what medications a patient has had. This can lead a nurse then giving a patient the same medication again, which carries the risk of overdose. No patient harm was discovered as a result of the missing lorazepam.'* [sic]

The panel noted that the two instances of dishonesty took place over a single nightshift. On one occasion he deliberately sought somewhere to sleep where he was unlikely to be disturbed, despite having rostered himself to take observations during this period, this meant that he failed to undertake the necessary observations, so he falsely completed documentation to give the impression he had undertaken observations in a timely manner and on the other occasion, copied and pasted the majority of the SCO report from the previous night shift. The panel determined that the dishonesty on these two occasions was opportunistic in nature.

The panel also noted that Mr Baffour did not initially accept that he had been dishonest during the probationary meeting and instead sought to deflect responsibility. The panel determined that the nature of Mr Baffour's dishonest

conduct, which put vulnerable patients at risk of harm, breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel determined whether the concerns arising from the charges found proved could be addressed by Mr Baffour. The panel considered that failings in Mr Baffour's clinical practice may be remediable through training, reflection, and evidence of strengthened practice. However, the panel noted that Mr Baffour has shown a lack of insight into his misconduct.

The panel noted that it has no evidence that Mr Baffour has completed any training courses in the relevant areas of concern. The panel also acknowledged that there was very limited evidence of insight or remorse in Mr Baffour's reflective statement, which addressed only Charge 13. The panel noted that the statement did not demonstrate accountability for his responsibilities as the only senior nurse on duty, nor an understanding of the impact of his actions on the vulnerable patients in his care. Furthermore, the panel noted that the statement was self-focused on Mr Baffour's own priorities, rather than the priorities of his patients, colleagues, the nursing profession and the wider public.

The panel considered that Mr Baffour has failed to recognise the importance of prioritising patient safety and is yet to demonstrate full insight into the impact of his behaviour. The panel considered that Mr Baffour's journey of remediation requires him to step back fully and objectively to reflect on his misconduct, rather than seeking to deflect to the perceived failings of others.

On balance, weighing the scale of Mr Baffour's misconduct, its impact on his patients, his colleagues and the wider public confidence in the nursing profession and in light of the lack of any insight and remediation, the panel determined that this was indicative of a deep-seated attitudinal issue. In particular, the panel was of the view that Mr Baffour has not demonstrated any sufficient level of regard for patient safety or an understanding into his dishonesty.

In light of this, the panel was not satisfied that Mr Baffour's misconduct has been remediated. Accordingly, the panel determined that Mr Baffour's misconduct is likely

to be repeated. In prioritising his own concerns over the safety and wellbeing of those in his care, the panel concluded that there remains a real risk of the misconduct being repeated. Consequently, the panel determined that limbs a, b, and c of the *Grant* test are engaged as to the future, due to Mr Baffour's lack of remorse, insight and strengthened practice. In light of these concerns, particularly the dishonesty related to clinical practice, the panel therefore determined that a finding of current impairment is necessary on the ground of public protection.

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 professional standards for members of those professions.

The panel had regard to the serious nature of Mr Baffour's misconduct and the public protection issues identified. It determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case. Furthermore, the panel noted that a member of the public would be concerned if a finding of impairment were not made. 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 Mr Baffour's fitness to practise is currently impaired on both public protection and public interest grounds.

### **Interim order**

Following the determination of misconduct and impairment, after careful and considered reflection, the panel adjourned this hearing due to a lack of time to conclude the sanction stage of these proceedings.

Mr Radley made an application for an interim suspension order for 12 months due to the facts found proved by the panel. He submitted that an interim order is required on the grounds of public protection and in the public interest in light of the findings of this panel. He submitted that the appropriate order would be an interim suspension order. This application was made under Rules 32(5) of the Rules.

### **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 noted in its findings that it considered that there was a risk of harm to patients.

The panel considered that it has found serious attitudinal concerns arising directly out of Mr Baffour's clinical practice and found a high risk of repetition. The panel concluded that it would be unable to formulate any workable conditions to address these attitudinal issues. Given this finding, the panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case. The panel considered the impact the imposition of an interim suspension order would have on Mr Baffour, however the panel determined that the necessity of an interim order on public protection and public interest grounds outweighs any impact to Mr Baffour.

At the time of making this decision, it has been indicated to the panel that dates to resume these proceedings will not be before January 2026. The panel acknowledged that no dates for the resuming of this substantive hearing have been confirmed at the imposition of this interim suspension order. The panel therefore imposed an interim suspension order for a period of 12 months in order to adequately protect the public and maintain public interest until the resuming dates of this substantive hearing.

## **Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mr Baffour was not in attendance and that the Notice of Hearing letter had been sent to Mr Baffour's registered email address by secure email on 14 January 2026.

Mr Radley, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, and, amongst other things, information about Mr Baffour's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Baffour has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

## **Decision and reasons on proceeding in the absence of Mr Baffour**

The panel next considered whether it should proceed in the absence of Mr Baffour. It had regard to Rule 21 and heard the submissions of Mr Radley who invited the panel to continue in the absence of Mr Baffour. He submitted that Mr Baffour had voluntarily absented himself.

Mr Radley submitted that there had been no engagement in recent terms by Mr Baffour with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel decided to proceed in the absence of Mr Baffour. In reaching this decision, the panel considered the submissions of Mr Radley and the advice of the legal assessor. It paid particular regard to the factors set out in the decision of *R v Jones and General Medical Council v Adeogba* [2016] EWCA Civ 162 and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Baffour;
- Mr Baffour has not engaged with the NMC or responded to any of the letters sent to him about this hearing;
- Mr Baffour has not provided the NMC with details of how he may be contacted other than his registered address;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- The charges relate to events that occurred on or before 2021;
- And there is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Baffour in proceeding in his absence. However, the panel determined that Mr Baffour has had approximately five months since the handing down on the facts and misconduct and impairment stages of the hearing to assemble evidence and make arrangements to either attend the hearing or send a representative to advance his interests, and has chosen not to. Consequently, any limited disadvantage is a consequence of Mr Baffour's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Baffour.

## **Sanction**

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Baffour off the register. The effect

of this order is that the NMC register will show that Mr Baffour has 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**

Mr Radley directed the panel to the NMC Sanction guidance and provided the following written submission:

*'The Panel will be seeking to find a fair balance between Mr Baffour's rights and our overarching objective of public protection (Huang v Secretary of State for Home A Department [2007] UKHL 11).*

*The NMC's case is that The FTP committee must restrict and justifiably can restrict Mr Baffour's right to practice in this case. The panel will consider whether the sanction with the least impact on Mr Baffour's practise would be enough to achieve protection in the public interest, looking at the reasons why he is not currently fit to practise and any aggravating or mitigating features. The sanction will of course be considered from the least serious to the most serious, to achieve its objectives.*

*The representations on aggravating factors are:*

- *Registered nurses occupy a position of privilege and trust, they must maintain professional boundaries and act within their Code.*
- *These are actions took place over a period of time (two referrals).*
- *The potential serious impact on vulnerable mental health patients when Mr Baffour was the only nurse on duty behaving in this way. The panel identified falsifying records and failure to undertake observations.*
- *Failures in medications management and related risk.*

- *Lack of understanding into failings. Mr Baffour's reflection lacked acceptance of wrongdoing.*
- *Impact on the profession and the reputation of nurses. The panel having recognised this concern.*
- *Sleeping on duty charges 1, 2 and 13.*
- *Grant test – four limbs are engaged.*
- *Breaching a number of fundamental tenets of the profession.*
- *Public interest is engaged. How would a reasonable member of the public react to a nurse found to be acting dishonestly in these circumstances. This is particularly in relation to charges 5 and 12.*
- *Detrimental effects of service users relating to safety (leaving the secure door open), in relation to charge 7.*

*The mitigating features are:*

- *Previous good character.*
- *Some recognition of Mr Baffour's reflection.*

*In regard to the proposed sanction, it is submitted that taking no action would not reflect the gravitas of the case.*

*It is submitted that in regard to a caution order, the public would expect a registrant to be sanctioned in at least a marking of the charge proven by the Panel.*

*It is submitted that this case would not be appropriately satisfied by a conditions or practice order for the following reasons:*

- *There would appear to be attitudinal issues towards Mr Baffour's acts.*
- *The actions proven are too serious for a conditions or practice order.*
- *Workable conditions could not reasonably be drafted to address the concerns.*

*It is submitted that a suspension order is not appropriate for this case. The NMC's guidance on suspension orders states it may be appropriate if the following apply:*

- A single instance of misconduct but where lesser sanction is not sufficient.*
- No evidence of harmful deep-seated attitudinal or personality problems.*

*The conduct has occurred on more than one occasion there are two concerns open in this case. Deep seated attitudinal concerns are present and identified by the panel.*

*Evidence of the behaviour over a period of time compounded by repeated dishonest actions and reduced to writing. This was not a single incident of misconduct, it was a cumulative continued dishonesty. There is insufficient clear insight into the misconduct actions. It is therefore submitted that Mr Baffour's behaviour is inconsistent with him remaining on the Register.*

*In regard to a striking-off order, this is appropriate when the following matters of guidance are engaged. They are;*

- Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
- Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate 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?*

*It is submitted that Mr Baffour's actions raise fundamental concerns around his professionalism and trustworthiness as a nurse. This is also a misuse of his position of trust to his employer. The conduct found proven here is very serious involving instances of dishonesty, cumulative acts compounding the*

*situation. The actions of falsifying records to coverup failing to carry out observations and his attempt to falsify handover / SCO report is an attempt to cover up clinical failings.*

*The NMC guidance on sanctions for serious cases, more serious dishonesty can involve:*

- *Was a deliberate attempt to breach the professional duty of candour by covering up his actions when things went wrong.*
- *Direct risk to people receiving care.*

*The dishonesty of Mr Baffour in this case raises fundamental concerns about his professionalism. Public confidence in the nursing profession has been called into question if he was not removed from the register and a striking-off would be the only sanction sufficient to maintain professional standards. The NMC therefore ask the Panel to consider a 'strike off' in this case on the basis of both public protection and public interest grounds.'*

The panel accepted the advice of the legal assessor.

### **Decision and reasons on sanction**

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

The panel took into account the following aggravating features:

- Abdicating of responsibility for residents and not supporting junior staff as the only registered nurse on duty.

- Presented a risk of harm to vulnerable patients by falsifying records and not undertaking care.
- Limited evidence of insight, remorse and remediation.
- Repeated episodes of dishonesty.
- Failure to engage with the NMC as a regulator from the misconduct and impairment stage of proceedings (Stage 2).

The panel noted that there were no mitigating features in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case 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 Mr Baffour’s actions were not at the lower end of the spectrum, as two charges were found proved relating to dishonesty. In light of the seriousness of Mr Baffour’s misconduct and the public protection issues identified, the panel determined that a sanction that does not restrict Mr Baffour’s 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 Mr Baffour’s 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 involved two incidents of dishonesty in relation to falsifying medical records. The panel determined that there were some concerns in the charges found proved that could be addressed through retraining. It noted that there was no evidence before it to demonstrate that Mr Baffour has undertaken relevant training courses or engaged in reflective practice to address any of the concerns arising from his conduct. The panel determined that Mr Baffour had not demonstrated any evidence that he has remorse for his actions, has developed insight or has taken steps to remediate his conduct.

The panel determined that Mr Baffour's dishonesty indicated that he has an attitudinal issue. It considered that given the repeated episodes of dishonesty and Mr Baffour's sustained lack of insight into his 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 Mr Baffour's conduct, which includes deep-seated attitudinal issues, the panel concluded that it would not be possible to formulate such conditions. Furthermore, the panel did not have confidence that any such order would be complied with in any event, given Mr Baffour's continued disengagement with the proceedings. Additionally, the panel had no evidence before it in the form of an indication from Mr Baffour that he wished to obtain a nursing role in the future. 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 Mr Baffour’s lack of remorse, insight and remediation, coupled with his continued non-engagement with these proceedings, a suspension order would not be sufficient to protect the public in the longer term without effective engagement by Mr Baffour, neither would suspension serve to uphold the public interest. The panel noted that, following the case becoming part-heard in November 2025, Mr Baffour was subject to a period of interim suspension. During this time,

despite being aware of the findings on facts, misconduct and impairment, the panel has no evidence that he has made any attempt to demonstrate remediation. The panel therefore determined that there was no evidence before it that Mr Baffour would address his shortcomings over the course of another 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 imposing a suspension order would give Mr Baffour another opportunity to engage with the proceedings, address his behaviour and demonstrate insight. However, given Mr Baffour's deep-seated attitudinal issues combined with a sustained lack of engagement, remorse, evidence of insight, or remediation, including any positive work testimonials, the panel considered that there is no realistic prospect that Mr Baffour would address the concerns to such an extent that he 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 Mr Baffour's misconduct, which includes deep-seated attitudinal issues involving dishonesty and a disregard for patient safety, raises fundamental questions about his professionalism. The panel noted that this includes serious attitudinal issues related to maintaining patient safety. It therefore determined that public confidence in the profession could not be maintained if Mr Baffour was permitted to remain on the register, particularly in view of his lack of remediation.

The panel considered that Mr Baffour's actions represented significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel considered that Mr Baffour's actions were not a single event and amounted to a course of long-standing deception which took place between October 2020 and June 2021.

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. Mr Baffour's misconduct involved two episodes of dishonesty which put patients at risk of 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, and given Mr Baffour's continued lack of engagement with the proceedings following the imposition of an interim suspension order after the misconduct and impairment stage (Stage 2), it did not consider this to be a realistic prospect. The panel concluded that Mr Baffour's conduct was serious and that permitting him 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 Mr Baffour's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, 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 Mr Baffour in writing.

### **Interim order**

The panel took account of the submissions made by Mr Radley. He 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. He 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.

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 Mr Baffour 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 Mr Baffour is sent the decision of this hearing in writing.

That concludes this determination.