Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 20 – Thursday, 23 April 2026
and
Monday, 27 – Wednesday, 29 April 2026

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

Name of Registrant:	**Florence Ayodele Fayomi**
NMC PIN:	03A0310O
Part(s) of the register:	Registered Nurse – Adult Nurse – sub part 1 RN1 – Adult nurse (level 1) January 2003
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	David Hull (Chair, lay member) Linda Holloway (Registrant member) Deborah Morel (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Monsur Ali
Nursing and Midwifery Council:	Represented by Rosie Welsh, Case Presenter
Mrs Fayomi:	Not present and not represented
Facts proved:	Charges 1(a), (b), (c), (d), (e),(f), 2, 3, 4(a), (b), (c), (d), (e) and 5 (except for (4f), (4g), (4(h)).
Facts not proved:	Charges 4(f),(g) and (h)
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 Mrs Fayomi was not in attendance and that the Notice of Hearing letter had been sent to her email address on 19 March 2026.

Ms Welsh, 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 virtual hearing link of the hearing and, amongst other things, information about Mrs Fayomi’s right to attend, be represented and call evidence, as well as the panel’s power to proceed in her absence.

In light of all of the information available, the panel was satisfied that Mrs Fayomi had 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 Mrs Fayomi

The panel next considered whether it should proceed in the absence of Mrs Fayomi. It had regard to Rule 21 of the Rules and heard the submissions of Ms Welsh who invited the panel to continue in the absence of Mrs Fayomi. Ms Welsh submitted that Mrs Fayomi had voluntarily absented herself, that witnesses on standby to give evidence would be inconvenienced by the case not proceeding, and that it would be in the public interest to proceed with the hearing.

Ms Welsh referred the panel to a telephone call from Mrs Fayomi to the NMC Case Officer dated 7 April 2026 which states:

‘Registrant Florence returned my call.

She wanted to ask how she can withdraw from the case. I asked what she means and she said she hasn't worked for years and doesn't see the need. I advised that unfortunately that wasn't how it works and that the panel needs to consider the matters referred to them.

I acknowledged that she previously applied to be removed from the register which was denied due to the allegations but explained that she does not need to attend the hearing if she doesn't want to take part and that it won't be held against her.

She said that’s what she would prefer and she won't be taking part but is happy for the hearing to proceed without her. I said I would make a note and we would inform the panel and that she would be sent the decision when its been made.

She thanked me for my help and said that she's relieved and feels better.’

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *‘with the utmost care and caution’* as referred to in NMC guidance based on principles in the case of *R v Jones (Anthony William) (No.2)* [2002] UKHL 5.

The panel decided to proceed in the absence of Mrs Fayomi. In reaching this decision, the panel considered the submissions of Ms Welsh, and the email sent by telephone call from Mrs Fayomi to the NMC Case Officer dated 7 April 2026.

The panel had 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 had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Fayomi had informed the NMC that she does not intend to attend the hearing;
- No application for an adjournment had been made by Mrs Fayomi;
- Three witnesses were on standby to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer and, as they are involved in clinical practice, the patients who need their professional services; and
- There was a strong public interest in the expeditious disposal of the case.

In light of the above, the panel concluded that:

- Mrs Fayomi had voluntarily absented herself;
- There was no reason to suppose that adjourning would secure her attendance at some future date;
- These are serious charges;
- These matters are six years old;
- It is in the public interest that these matters are dealt with expeditiously;
- There are three witnesses in waiting to give live evidence; and
- It is in the interest of all parties to proceed with the hearing.

The panel noted that there would be some disadvantage to Mrs Fayomi in proceeding in her absence. Although the evidence upon which the NMC relied will have been sent to Mrs Fayomi at her registered email address, she would not be able to challenge the evidence relied upon by the NMC in person and would not be able to give evidence on her own behalf. However, in the panel's judgement, this could be mitigated. The panel could make allowance for the fact that the NMC's evidence would not be tested by cross examination and, of its own volition, could explore any inconsistencies in the evidence which it identified. Furthermore, the limited disadvantage was the consequence of Mrs Fayomi's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it was fair, appropriate and proportionate to proceed in the absence of Mrs Fayomi. The panel would draw no adverse inference from Mrs Fayomi's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1. On 24 February 2019, in relation to Resident A:
    a. Provided incorrect information to a 999 operator, in that you stated that Newington Court Care Home ("Home") had an automated external defibrillator ("AED").
    b. Told the 999 operator that you were going to get the AED from another room, when you knew this to be untrue.
    c. Was not able to provide clear and concise details to the 999 operator in that:
        i. Did not know the Resident's date of birth.
        ii. Did not know whether or not the Resident had a Do Not Attempt Resuscitation.
    d. Did not follow the 999 operator's instructions in relation to assisting Resident A.
    e. Left Resident A to attend to Resident E's peg feed.
    f. Your actions in relation to charge 1a and or 1b was dishonest in that you sought to create the impression that the Home had an AED when you knew this to be untrue.

2. On 22 / 23 September 2019 in relation to Resident B failed to turn the Resident every 2 hours according to their care plan.

3. On 26 September 2019 in relation to Resident C:
    a. Attempted to use the hoist to transfer the Resident from the lounge to their bedroom.
    b. Applied two incontinence pads on Resident C instead of one.

4. On 26 September 2019 in relation to Resident D who suffered an unwitnessed fall:
    a. Did not check the Resident for physical injuries.
    b. Did not check their vital signs.
    c. Did not check for head injuries.
    d. Did not speak to the Resident to see if they are in pain or discomfort.
    e. Inappropriately pulled the Resident by their wrists and put them back on their wheelchair and or bed.
    f. Did not complete an incident report.
    g. Did not inform the Resident's next of kin at the time or in the morning.
    h. Did not carry out observations throughout the shift.

5. Breached the duty of candour in that you knowingly provided inconsistent explanations of your conduct in relation to charges 1 to 4 to Newington Court Care Home in order to conceal your actions/omissions.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Welsh under Rule 31 to allow the local interview notes dated 27 September 2019 of Sally Wakeling into evidence. Ms Wakeling was not present at this hearing.

Ms Welsh submitted that the panel should admit the hearsay evidence pursuant to Rule 31, which permits the panel to receive evidence in any form where it is relevant and fair to do so. She relied on *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), which confirms that hearsay evidence may be admitted where appropriate, although caution should be exercised. Ms Welsh submitted that the panel must consider first whether the evidence is admissible, and separately what weight should later be attached to it.

Ms Welsh submitted that the witness had previously worked as a carer at the Home and had raised concerns shortly after the events in question. Her account was recorded during the employer's investigation soon after the incident. Ms Welsh explained that the witness was not attending this hearing because she no longer worked in the sector, did not wish to participate in the proceedings, and preferred that evidence was read into the evidence rather than give live evidence.

Referring to the principles in the case of *Thorneycroft*, Ms Welsh submitted that the evidence was not sole or decisive. She said there were other witnesses available to give live evidence in relation to the matters alleged, together with contemporaneous care records, observation charts, care plans, risk assessments, disciplinary records, and records of Mrs Fayomi's responses when the allegations were first put to her. She submitted that this wider body of evidence allowed the hearsay material to be tested against other available evidence.

Ms Welsh accepted that the witness could not be cross-examined. However, she submitted that Mrs Fayomi had challenged the allegations at the local level, and her denials and explanations were contained within the documents before the panel.

Ms Welsh further submitted that there was no evidence of fabrication or bad faith, and that the account was given during an internal investigation when the witness would be expected to provide a truthful account.

Ms Welsh submitted that the allegation was serious because it related to patient care and potential risk of harm and potential consequences regarding Mrs Fayomi's registration were equally serious.

Ms Welsh submitted that notice had been given to Mrs Fayomi in advance that an application would be made to admit the material as hearsay, and copies of the relevant documents had been provided. In all the circumstances, Ms Welsh invited the panel to conclude that admission of the evidence would be fair and in the interests of justice.

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

The panel gave careful consideration to the application to admit the hearsay evidence. The panel reminded itself of Rule 31 and the principles set out in *Thorneycroft v NMC*. The panel understood that it must first decide whether the evidence was relevant and fair to admit, and then decide at a later stage what weight, if any, should be attached to that evidence.

The panel first considered relevance. The panel noted that the document was an interview note taken during the employer's investigation shortly after the events alleged in Charge 2. The panel was of the view that the evidence was directly relevant to the allegation, as it related to the care said to have been provided to the resident on the dates in question. Further, this was direct evidence from a witness who was present at the time of the alleged incidents. The panel also noted that the account formed part of the wider evidential background to the charge.

The panel then considered whether the evidence was sole or decisive. The panel determined that it was not. The panel noted that there were contemporaneous care records, turning charts, risk assessments, nursing notes and other documentary evidence before it. The panel also noted that other witnesses were due to give live evidence. In those circumstances, the panel concluded that the hearsay material was only one part of the overall evidence.

The panel next considered the nature and extent of any challenge to the evidence. The panel recognised that Ms Wakeling was not present and could not be cross-examined. However, the panel noted that Mrs Fayomi had been provided with the material in advance and the NMC had also provided guidance regarding this application. The NMC had specifically notified Mrs Fayomi that an application would be made to admit it, and Mrs Fayomi had been given an opportunity to object or respond. The panel further

noted that Mrs Fayomi chose not to attend the hearing. The panel was therefore satisfied that fair notice had been given in relation to this evidence.

The panel considered whether there was any reason to believe the account had been fabricated. The panel found no evidence of any improper motive or bad faith. The panel noted that the account was given as part of an internal investigation soon after the events, which supported its reliability.

The panel also noted that the allegation was serious, as it concerned patient care and potential risk of harm and also the seriousness of the charges Mrs Fayomi faces, which made it important that all relevant evidence is considered.

Having considered all the circumstances step by step, the panel determined that it was fair and appropriate to admit the hearsay evidence. The panel concluded that the absence of a formal witness statement and the witness's non-attendance were matters relevant to weight rather than admissibility. The panel therefore admitted the evidence and will decide what weight to attach to it after hearing and evaluating all of the evidence in the case.

Background

The charges arose whilst Mrs Fayomi was employed as a registered nurse by Barchester Healthcare at Newington Court Care Home (the Home). The allegations relate to a number of incidents involving residents at the Home during 2019, and concern Mrs Fayomi's clinical practice, decision-making, communication, and standards of care.

The first incident concerned Resident A. Emergency services received three calls in relation to Resident A, during which it was reported that the resident had fallen in the bathroom and had been placed on the floor. By the third call, Resident A's condition had deteriorated, and the call handler gave instructions which included commencing CPR.

Following the call, emergency services made a safeguarding referral, which led to an internal investigation. The allegation concerned Mrs Fayomi's conduct and communication with the 999 call handler, including that she stated that the Home had an AED defibrillator when it did not, and that she left Resident A during the call to attend to another resident, after which she stopped responding to the operator.

The employer investigated the incident and held an investigation meeting with Mrs Fayomi on 8 April 2019, followed by a disciplinary hearing later that month. As an outcome of that process, it was agreed that Mrs Fayomi would undertake further CPR and AED training, move temporarily to day shifts, and shadow other members of staff.

Following further training and a performance plan, she later returned to night shifts from September 2019.

The second set of allegations concern Residents B, C and D in September 2019.

Resident B was vulnerable to pressure sores and required repositioning every two hours in accordance with their care plan. It is alleged that this did not occur on 22/23 September 2019. These concerns were put to Mrs Fayomi during an investigation meeting on 3 October 2019 and again at a disciplinary meeting the following day. Mrs Fayomi disputed the allegations, stating that she had completed the first and last turns and that other staff should have assisted with repositioning.

Further allegations concern incidents involving Residents C and D on the night shift of 26 September 2019.

In relation to Resident C, it is alleged that during this shift Mrs Fayomi used two incontinence pads instead of one. It is also alleged that, during the same shift, Mrs Fayomi used a hoist incorrectly and attempted to transfer Resident C to their bedroom from the lounge.

Resident D was found on the bedroom floor by Ms Tajes, who activated the emergency call bell. It is alleged that Mrs Fayomi entered the room, did not carry out appropriate

checks, and pulled the resident by the arms into a wheelchair without taking observations or checking for injury. Mrs Fayomi denied this and stated that she had checked the resident and taken observations.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Fayomi.

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:

- Amanda Oxley: Was employed as the Home Manager at the time of the incidents for the Home and carried out the disciplinary proceedings.
- Sonia Tajes: Was employed by the Home as a Care Assistant at the time of the incidents.
- Charles Whibley: Was employed by the Home as the Clinical Nurse Manager at the time of the incidents.

After the live evidence, the panel heard three audio recordings of the 999 calls which were of good quality and was further assisted by accompanying transcripts.

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 the NMC.

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

Charge 1a

1. On 24 February 2019, in relation to Resident A:

    a. Provided incorrect information to a 999 operator, in that you stated that Newington Court Care Home ("Home") had an automated external defibrillator ("AED").

This charge is found proved.

The panel considered Charge 1a and the evidence relating to the telephone call made to emergency services on 24 February 2019 in respect of Resident A. The panel had regard to the documentary evidence, the audio recording of the 999 call, the transcript of that call, and the oral evidence heard during the proceedings.

The panel was satisfied that Mrs Fayomi was the person speaking to the 999 operator. In the interviews with Ms Oxley and Mr Whibley, Mrs Fayomi accepted that it was her on the call. Ms Oxley also confirmed this during oral evidence before the panel. The panel further noted that Mrs Fayomi identified herself by name during the call.

The panel listened to the audio recording and found the quality to be clear. The panel was able to hear that Mrs Fayomi stated there was an AED at the Home and that she put the phone down to get it. The panel found that the audio recording was consistent with and corroborated by the written transcript. It found this to be compelling and

unequivocal evidence. In the transcript of the audio, dated 24 February 2019, it is stated as follows:

> Operator *'And have you got an AED there at all?'* Mrs Fayomi replied with *'Pardon'* and the operator then said *'Have you got an AED or a de-fib there?'* Mrs Fayomi stated *'Yes'.*

The panel noted that the call recording was technically hearsay evidence but had determined that it was fair and appropriate to admit it. The panel was of the view that the recording was reliable evidence. The operator asked a number of clear and direct questions, and Mrs Fayomi gave a number of clear responses confirming that there was an AED at the Home. The panel accepted the written and oral evidence of Ms Oxley that the Home did not in fact have an AED and nor had it ever had one.

The panel also considered Mrs Fayomi's account given during the disciplinary meeting on 12 April 2019. The panel noted that Mrs Fayomi did not dispute what she had said during the call, but instead sought to explain it. Mrs Fayomi stated *'I didn't understand'*, *'I was disoriented'* and *'I was panicking and confused'*. The panel considered that these comments amounted to an explanation for the incorrect information rather than a denial.

Having taken all of the evidence into account, the panel determined that Mrs Fayomi did provide incorrect information to the 999 operator by stating that the Home had an AED.

Accordingly, the panel found Charge 1a proved on the balance of probabilities.

Charge 1b

b. Told the 999 operator that you were going to get the AED from another room, when you knew this to be untrue.

This charge is found proved.

The panel considered Charge 1b and the evidence relating to the telephone call made to emergency services on 24 February 2019 in respect of Resident A. The panel had regard to the audio recording of the 999 call, the transcript of that call, and the surrounding documentary evidence as well as the oral and written evidence of Ms Oxley and Mr Whibley.

The panel had already determined that Mrs Fayomi was the person speaking to the 999 operator during the call. The panel was therefore satisfied that the statements made during the call were made by Mrs Fayomi. The panel listened to the recording and considered the transcript carefully.

The operator in the call stated, which appears in the transcript dated 24 February 2019 says *'…Could you get the AED?*' and Mrs Fayomi stated *'What you call AED?'* the operator said *'a defibrillator'* Mrs Fayomi stated *'Ok, ok.'* The operator said *'have you got one?'* Mrs Fayomi stated *'Yes, we got one'* Mrs Fayomi stated *'… I'm going to collect it'.* She also said *'I'm going to the […] room to collect it'*. The panel further noted that Mrs Fayomi went on to tell the operator that the AED was there with her and that she was turning it on.

The panel was of the view that these were clear statements by Mrs Fayomi that she was going to retrieve an AED from another room. The panel accepted the evidence already before it that the Home did not have an AED. In those circumstances, the panel determined that Mrs Fayomi knew the information she was giving to the operator was untrue when she said she was going to collect the device.

The panel considered whether there could have been confusion or misunderstanding during the emergency situation. However, the panel noted that Mrs Fayomi did not merely answer yes to a single question. She went further and stated that she was going to collect the AED and referred to going to another room to get it. The panel considered this to be a deliberate representation that the equipment existed and could be retrieved. In her interview with Ms Oxley dated 12 April 2019 Mrs Fayomi stated that she was disorientated. In her investigatory meeting with Mr Whibley, Mrs Fayomi denied that the 999 operator asked her if she had an AED, stating *'she didn't ask that question.'*

Having taken all of the evidence into account, the panel determined that Mrs Fayomi told the 999 operator that she was going to get the AED from another room, when she knew this to be untrue. Accordingly, the panel found Charge 1b proved on the balance of probabilities.

Charge 1c

c. Was not able to provide clear and concise details to the 999 operator in that:

    i. Did not know the Resident's date of birth.

This charge is found proved.

The panel considered the written and oral evidence of Ms Oxley and Mr Whibley in relation to the telephone calls made to emergency services on 24 February 2019 in respect of Resident A. The panel had regard to the audio recordings, the transcripts, and the surrounding evidence. The panel also noted the oral evidence of Ms Oxley who described the SBAR (Situation, Background, Action and Response) process in place for making emergency calls from the Home. There was a notebook next to every phone detailing the information to be gathered before calling an ambulance including date of birth, DNAR status and a set of observations. Ms Oxley also told the panel about patient folders which included information such as the DNAR status.

The panel had already determined that Mrs Fayomi was the person speaking to the 999 operator. Having listened to the recordings, the panel was satisfied that she was asked for the Resident A's date of birth but was unable to provide it. Instead, she repeatedly referred to the resident's age.

The operator asked *'And how old is she?'* Mrs Fayomi *'she's'.* The operator *'Or her date of birth, if that's easier.'*

The operator asked '*what's her date of birth?'* Mrs Fayomi replied *'She's 83 years, love'.*

The panel noted that across the three calls, the operator made several attempts to obtain the Resident's date of birth. On each occasion, Mrs Fayomi responded with either with the Resident's age or year of birth, rather than the requested information. The panel concluded that her answers were neither clear nor responsive to the question asked.

Having taken all of the evidence into account, the panel determined that Mrs Fayomi was not able to provide clear and concise details to the 999 operator in that she did not know the resident's date of birth.

Accordingly, the panel found Charge 1c(i) proved on the balance of probabilities.

Charge 1c

ii. Did not know whether or not the Resident had a Do Not Attempt Resuscitation.

This charge is found proved.

The panel considered the evidence relating to the 999 call made on 24 February 2019 in respect of Resident A. The panel had regard to the audio recording, transcript, and associated evidence.

The panel had already found that Mrs Fayomi was the person speaking to the 999 operator. Having listened to the recording, the panel noted that she told the operator the Resident had a Do Not Attempt Resuscitation (DNAR) order in place.

Ms Oxley told the panel in her oral evidence that there was a notebook next to every phone detailing the information to be gathered before calling an ambulance including date of birth, DNAR status and a set of observations. Ms Oxley also told the panel about patient folders which included information such as the DNAR status.

When Mrs Fayomi was on the phone with the operator she said *'She has a… Let me see if she has a DNAR'*. The operator said *'Is it signed and in date?'* Mrs Fayomi stated

'…Yes. She has no DNAR, no.' The operator then said '*She doesn't have a DNAR, okay. So you need to switch your phone onto hands-free and loudspeaker now, okay?'*

The panel considered that this exchange showed inconsistency and confusion in Mrs Fayomi's responses. The panel was of the view that the answers given were not clear or reliable, particularly in response to direct and straightforward questions from the operator about the existence of a DNAR.

Having taken all the evidence into account, the panel determined that Mrs Fayomi did not know whether or not the resident had a DNAR in place. Accordingly, the panel found Charge 1c(ii) proved on the balance of probabilities.

Charge 1d

d. Did not follow the 999 operator's instructions in relation to assisting Resident A.

This charge is found proved.

The panel considered Charge 1d and the evidence relating to the 999 call made on 24 February 2019 in respect of Resident A. The panel had regard to the audio recording, transcript, and the oral and written evidence of Ms Oxley and Mr Whibley. The panel found the quality of the audio recording to be clear and noted that the transcript provided a reliable timeline of events. The panel had already determined that Mrs Fayomi was the person speaking to the operator.

The panel noted that the operator gave clear and repeated instructions to assist Resident A. Mrs Fayomi was asked to place the Resident onto her back so that appropriate assistance could be given. The panel heard movement in the background during the call, which was consistent with activity taking place at the scene.

The operator stated: '*Okay, lay her onto her back on the floor for me.'*
Mrs Fayomi: *'We can't because the hand is under the abdomen and she's lying down on the hand. She's lying on the floor, and the right hand is the wounded hand.'*

Operator said: *'Okay, just lay her onto her back on the floor. I know she's on the floor, so just lay her onto her back straightaway for me, and kneel by her side, okay?'*

Mrs Fay: *'Okay.'*
Operator: *'Have you done that?'*
Mrs Fay: *'No, … No, somebody's downstairs. Huh? Okay, yes. Okay, the ambulance is here, my dear.'*
Mrs Fay: *'The ambulance is here already, in the room.'*
Operator: *'In the room with the patient?'*
Mrs Fay: *'Yeah, I'm in the room with the patient. The ambulance is here.'*
Operator: *'Is the ambulance crew in the room with the patient?'*
Mrs Fay: *'No. They are just arriving to the room.'*
Operator: *'Okay, I understand that. We need to carry on doing this until they get in the room with the patient, okay?'*

The panel was of the view that the operator's instructions were clear, direct, and repeated. The panel found that Mrs Fayomi did not comply with those instructions. The audio demonstrated that this continued over a number of minutes while the operator attempted to guide Mrs Fayomi through the emergency response.

The panel also noted evidence that Mrs Fayomi left Resident A during this critical period to attend to another resident, leaving no medically trained person with Resident A at an important stage of the emergency.

Having taken all of the evidence into account, the panel determined that Mrs Fayomi did not follow the 999 operator's instructions in relation to assisting Resident A. Accordingly, the panel found Charge 1d proved on the balance of probabilities.

Charge 1e

e. Left Resident A to attend to Resident E's peg feed.

This charge is found proved.

The panel considered Charge 1(e) and the evidence relating to the events of 24 February 2019 in respect of Resident A. The panel had regard to the audio recording of the 999 call, the transcript, the documentary evidence, and the evidence of Ms Oxley and Mr Whibley.

The panel considered the evidence of Ms Oxley. In her written statement dated 7 January 2025, Ms Oxley stated:

> *'Another concern from this incident was that during the 999 call, Florence went and attended to another resident. I think it was a bleep reminder that a resident needed a PEG feed. However, this is something that is not urgent and Florence should not have left the resident that was having an emergency. You can tell from the 999 transcript that Florence just walked away from the resident and stopped answering the 999 operator. I don't know what Florence was thinking. Florence denied having left the resident but it was clear in the transcript and that they heard her walking around.'*

The panel found this evidence to be consistent with the audio recording and transcript of the call. The panel noted that there were periods during the call when Mrs Fayomi stopped responding to the operator, and movement could be heard in the background. The panel considered this supported the account that Mrs Fayomi had moved away from Resident A during the emergency.

The panel also considered Mrs Fayomi's own explanations. In the interview notes dated 8 April 2019, Mrs Fayomi stated *'the beeping was … peg feed.'* In the disciplinary meeting notes dated 12 April 2019, when asked why she left, Mrs Fayomi explained that *'the beeper was going'.* The panel considered these accounts amounted to an acknowledgement that she had left Resident A because of the alert relating to another resident's PEG feed.

The panel was of the view that the evidence was clear and consistent. Ms Oxley's account, the transcript, the audio recording, and Mrs Fayomi's own explanations all

pointed to the same conclusion, namely that Mrs Fayomi left Resident A during an ongoing medical emergency in order to attend to Resident E's PEG feed.

Having taken all of the evidence into account, the panel determined that Mrs Fayomi left Resident A to attend to Resident E's PEG feed. Accordingly, the panel found Charge 1(e) proved on the balance of probabilities.

Charge 1f

Your actions in relation to charge 1a and or 1b was dishonest in that you sought to create the impression that the Home had an AED when you knew this to be untrue.

This charge is found proved.

The panel considered Charge 1(f) and whether Mrs Fayomi's actions in relation to Charge 1a and/or 1b were dishonest. In reaching its decision, the panel applied the principles in *Ivey v Genting Casinos* (UK) Ltd (t/a Crockfords Club) [2017] UKSC 67 and the NMC guidance DMA-8, namely first to determine Mrs Fayomi's actual state of knowledge or belief as to the facts, and then to consider whether, viewed objectively by the standards of ordinary decent people, her conduct was dishonest.

The panel first considered whether or not it had any evidence of an alternative explanation for Mrs Fayomi's conduct which points away from being dishonest. It considered that the responses provided by Mrs Fayomi in her interviews with Ms Oxley and Mr Whibley that she could not hear or understand the operator or that she was confused about what an AED is. However, having found the audio recordings to be both clear and compelling allied with evidence of the specific training Mrs Fayomi received regarding AEDs, the panel was satisfied that it could exclude these alternative explanations.

The panel considered Mrs Fayomi's knowledge and understanding of what an AED was. The panel had regard to the evidence of Ms Oxley, who stated that the Home did not have an AED at that time and in fact never had an AED. Further, Ms Oxley told the

panel there was no other piece of equipment at the Home which resembled an AED. The panel also considered Mrs Fayomi's training records, which showed that she had completed Basic Life Support training on 26 December 2017 and again on 26 October 2018. The panel noted that this training included CPR and AED instruction, and that Mrs Fayomi had passed both the practical and theoretical elements. The panel was therefore satisfied that Mrs Fayomi knew what an AED was and understood its purpose.

The panel then considered what Mrs Fayomi said during the 999 call. During the call, she stated that the Home had an AED, that she would get it, and later indicated that she had it and was turning it on. The panel noted that when the operator referred to a defibrillator, Mrs Fayomi did not state that she did not understand or did not know what was being referred to. Instead, she confirmed that the equipment existed and that she was retrieving it.

The panel considered Mrs Fayomi's later explanations. In the disciplinary meeting of 12 April 2019, when it was put to her that the Home did not have an AED, Mrs Fayomi said *'I didn't understand.,… I was disoriented…'*. The panel found these explanations to be inconsistent. The panel accepted that the situation was stressful, but noted that Mrs Fayomi repeated the false information on a number of occasions during the call, including after the operator had clarified what an AED was.

The panel also noted that Mrs Fayomi did not activate the emergency call bell or seek immediate assistance from other staff members. Instead, she gave the operator the impression that the Home had equipment available which it did not have. The panel was of the view that this was not a momentary lapse of understanding, but rather a deliberate and repeated attempt to create a false impression during an emergency situation.

Having taken all of the evidence into account, the panel determined that Mrs Fayomi knew the Home did not have an AED, yet told the operator that it did and that she was retrieving it. Applying the objective standards of ordinary decent people, the panel concluded that this conduct was dishonest. Accordingly, the panel found Charge 1f proved on the balance of probabilities.

Charge 2

> On 22 / 23 September 2019 in relation to Resident B failed to turn the Resident every 2 hours according to their care plan.

This charge is found proved.

The panel considered Charge 2 and the evidence relating to Resident B on the night shift of 22 / 23 September 2019. The panel had regard to the documentary evidence, the oral evidence of witnesses, and the hearsay evidence that had previously been admitted.

The panel first considered whether Resident B required repositioning every two hours. The risk assessment dated 16 September 2019 clearly stated that the Resident needed to be turned every two hours. The panel also noted that the Resident's care plan, skin integrity records, and assessment of care needs supported the requirement for regular repositioning. The panel was satisfied that there was clear and cogent evidence that Resident B was to be turned every two hours in accordance with the care plan.

The panel then considered Mrs Fayomi's responsibility for this care. The panel was satisfied that Mrs Fayomi was the registered nurse on the unit during the relevant shift and therefore held clinical responsibility for ensuring that the Resident's care plan was followed either directly by Mrs Fayomi or by others under her instruction. The panel was of the view that, whilst carers may assist with turning, the responsibility for overseeing and ensuring completion of that care rested with Mrs Fayomi.

The panel considered the evidence about what took place during the shift. It noted inconsistencies in Mrs Fayomi's various accounts in the investigation and disciplinary hearings with Ms Oxley and Mr Whibley. At times, she suggested that she had asked a care assistant to turn the Resident. At other times, she stated that she had turned the Resident herself. In the disciplinary meeting notes dated 4 October 2019, when asked why she did not carry out turning every two hours, Mrs Fayomi replied *'I was busy doing medications.'* She also stated *'I turned her twice.'* The panel considered that this

amounted to an acknowledgement that the required two-hourly turning had not been completed.

The panel also considered the hearsay evidence of Ms King, which it had admitted earlier in the proceedings. The panel found that evidence to be consistent with the other material before it, including the documentary records and Mrs Fayomi's own explanations. The panel was satisfied that this supported the allegation that the required turning had not taken place.

Having taken all of the evidence into account, the panel determined that turning the Resident twice during the course of a night shift was insufficient and did not comply with the care plan requiring repositioning every two hours. The panel concluded that Mrs Fayomi had a duty to ensure this care was provided and failed to discharge that duty. Accordingly, the panel found Charge 2 proved on the balance of probabilities.

Charge 3

On 26 September 2019 in relation to Resident C:

a. Attempted to use the hoist to transfer the Resident from the lounge to their bedroom.

This charge is found proved.

The panel considered Charge 3(a) and the evidence relating to Resident C on 26 September 2019. The panel had regard to the oral evidence of witnesses, the contemporaneous written material, and Mrs Fayomi's own account given during the employer's investigation.

The panel found the evidence of Ms Tajes to be clear and reliable. Ms Tajes had previous experience of using the hoist and was able to explain its proper use. She stated that the hoist should only be used to transfer residents from bed to chair or chair to bed, and not to move a resident from one room to another or from the corridor to the

room. The panel noted that both Ms Oxley and Ms Tajes said that using the hoist in the manner alleged would not be in line with accepted practice.

The panel also considered the handwritten statement of Ms Tajes. Although undated, the panel accepted that it was made contemporaneously and recorded concerns about the attempted transfer. The panel noted that Ms Tajes reported the matter to her line manager at the end of the shift, which supported the reliability of the account.

The panel then considered Mrs Fayomi's own explanation. In the meeting with Ms Oxley dated 12 April 2019, Mrs Fayomi stated *'I was scared because a carer said about the hoist.'* She also stated *'No from the corridor and then push her into the room.'* and *'she was inside and the hoist was in the corridor.'* The panel considered that Mrs Fayomi did not deny attempting to use the hoist, but instead sought to minimise the distance involved by saying it was only from the corridor into the room.

The panel accepted Ms Tajes's evidence and was of the view that had she not intervened, Mrs Fayomi would have proceeded with transferring the Resident using the hoist. The panel was satisfied that the attempted transfer was real and not merely a misunderstanding or discussion about possible options.

Having taken all of the evidence into account, the panel determined that Mrs Fayomi attempted to use the hoist to transfer Resident C to their bedroom. Accordingly, the panel found Charge 3(a) proved on the balance of probabilities.

Charge 3

b. Applied two incontinence pads on Resident C instead of one.

This charge is found proved.

The panel considered Charge 3(b) and the evidence relating to Resident C on 26 September 2019. The panel had regard to Ms Tajes's evidence, contemporaneous records, and Mrs Fayomi's own account during the employer's investigation.

The panel noted that Mrs Fayomi accepted applying two incontinence pads to Resident C during her meeting with Mr Whibley dated 3 October 2019. Mrs Fayomi was asked by Mr Whibley as following *‘on the 26th you worked with […] she stated that you double padded Resident C, is that true?’* Mrs Fayomi stated *‘Yes’.* The panel considered this to be a clear admission of the conduct alleged.

The panel also considered Mrs Fayomi’s explanation for doing so. Mr Whibley said *‘Why did you do that?’* Mrs Fayomi stated *‘Resident C has a wound on both side and I did it so that urine didn’t touch the wound.’* Mrs Fayomi further stated ‘*I’m not the first and the last to do it. The day shift do it. When she is in that position it is protecting them.’* The panel noted that Mrs Fayomi was therefore not denying the conduct, but seeking to justify it.

The panel also heard evidence from Ms Tajes, who witnessed the incident. Ms Tajes had made contemporaneous notes, which she confirmed during her oral evidence. Ms Tajes stated: *‘Florence took two pads, one inside the other one, I said to Florence that we cannot do that, is now allowed but she didn’t pay attention to me and she just carried on with it using both pads.’* The panel found this evidence clear, consistent, and supportive of Mrs Fayomi’s own admission.

The panel was satisfied that the combined evidence of Mrs Fayomi’s admission, her explanation, and the independent account of Ms Tajes established what had occurred. There was no material dispute that two pads had been used instead of one.

Having taken all of the evidence into account, the panel determined that Mrs Fayomi applied two incontinence pads on Resident C instead of one. Accordingly, the panel found Charge 3b proved on the balance of probabilities.

Charge 4

On 26 September 2019 in relation to Resident D who suffered an unwitnessed fall:

a. Did not check the Resident for physical injuries.

b. Did not check their vital signs.
c. Did not check for head injuries.
d. Did not speak to the Resident to see if they are in pain or discomfort.
e. Inappropriately pulled the Resident by their wrists and put them back on their wheelchair and or bed.

These charges are found proved.

The panel considered these charges collectively in the particular circumstances of this allegation.

The panel considered Charge 4 and the evidence relating to Resident D on 26 September 2019 following an unwitnessed fall. The panel had regard to the witness evidence, contemporaneous records, the relevant care documentation, and Mrs Fayomi's own account during the employer's investigation.

The panel noted that Ms Tajes was present and alerted Mrs Fayomi that Resident D was on the floor. Ms Tajes provided a contemporaneous written account and also gave oral evidence before the panel. The panel found her evidence to be clear, consistent, and reliable. Ms Tajes stated that she did not observe Mrs Fayomi carrying out the expected checks following the fall, which she had seen other registered nurses perform in similar circumstances.

The panel also noted the documentary care plan for Resident D, detailing what to do if Resident D fell which included following Barchester's management of falls protocol. Ms Oxley confirmed in her oral evidence that this included checking for physical injuries including a head injury, and recording vital signs before moving the resident. This also included asking if the resident was in pain, completing an incident form, informing the next of kin and performing observations of the patients throughout the shift.

The panel also considered Mrs Fayomi's responses during the meeting with Mr Whibley dated 3 October 2019. When Mr Whibley asked '*When people fall you need to do observations and vital signs. Did you do it and not record it?'* Mrs Fay replied *'No I*

didn't. ‘I felt her head, she had no bumps. I checked her body. ‘She said she was alright. ‘I didn't see signs or symptoms. ‘I went in 4 times but I didn't touch her or record it.’

The panel considered these answers carefully. Whilst Mrs Fayomi suggested that some limited checks had taken place, she expressly accepted that she had not carried out observations or vital signs.

The panel had regard to the Home’s training evidence. Ms Oxley stated that induction training included a falls programme and first aid training, including a course called Footsteps, which Mrs Fayomi completed on 16 February 2018. Ms Tajes also confirmed that she had completed the same training as part of her own induction. The panel was satisfied that Mrs Fayomi would have known the expected steps following an unwitnessed fall, including checking for injury, taking observations, assessing pain, and responding safely, prior to moving a patient.

In relation to the manner in which Resident D was moved, the panel accepted Ms Tajes’s evidence that Mrs Fayomi did not seek assistance and instead pulled the Resident up by the wrists. Ms Tajes described Mrs Fayomi as having pulled the resident by the wrists. Ms Tajes also told the panel that she was not involved at all in supporting or assisting this lifting mechanism by Mrs Fayomi. The panel found this evidence credible and consistent with the concerns raised at the time. The panel considered that such handling was completely inappropriate in the circumstances of an unwitnessed fall.

Having taken all of the evidence into account, the panel determined that Mrs Fayomi did not properly check Resident D for physical injuries, did not check vital signs, did not adequately check for head injuries, did not appropriately speak to the Resident to assess pain or discomfort, and inappropriately pulled the Resident by the wrists before putting them back in the wheelchair and/or bed. Accordingly, the panel found Charge 4a, 4b, 4c, 4d and 4e proved on the balance of probabilities.

Charge 4

f. Did not complete an incident report.

g. Did not inform the Resident’s next of kin at the time or in the morning.
h. Did not carry out observations throughout the shift.

These charges are found NOT proved.

The panel considered Charge 4(f), 4(g) and 4(h) in relation to Resident D following the unwitnessed fall on 26 September 2019. The panel had regard to the documentary evidence, witness evidence, and Mrs Fayomi’s responses during the employer’s investigation.

The panel reminded itself that the burden of proving the charges rests upon the NMC and that the standard of proof is the balance of probabilities. It was therefore for the NMC to provide sufficient evidence to establish each allegation.

In relation to Charge 4(f), the panel found that there was no documentary evidence or witness evidence to show that Mrs Fayomi failed to complete an incident report. No incident reporting records were produced, and no witness gave direct evidence establishing that this had not been done. The panel was therefore not satisfied that the allegation had been proved.

In relation to Charge 4(g), the panel found there was insufficient evidence to establish that Mrs Fayomi did not inform the resident’s next of kin at the time or in the morning. The panel noted that this issue was not specifically put to Mrs Fayomi during the local investigation meeting or disciplinary process, and there was no clear evidence from any witness dealing with this allegation.

In relation to Charge 4(h), the panel noted that Mrs Fayomi was asked in general terms whether she had checked on the resident, to which she said that she had checked four times. However, the panel considered that this was a broad question and answer, and there was no detailed evidence showing whether formal observations were or were not carried out throughout the shift. The panel concluded that the evidence was insufficient to prove the allegation.

Having taken all of the evidence into account, the panel determined that the NMC had not discharged its burden of proof in respect of Charges 4(f), 4(g) and 4(h). Accordingly, the panel found these charges not proved.

Charge 5

Breached the duty of candour in that you knowingly provided inconsistent explanations of your conduct in relation to charges 1 to 4 to Newington Court Care Home in order to conceal your actions/omissions.

This charge is found proved.

The panel considered Charge 5 and whether Mrs Fayomi breached the professional duty of candour by knowingly providing inconsistent explanations of her conduct in relation to Charges 1 to 4 in order to conceal her actions and omissions. The panel had regard to the NMC guidance DMA-8, '*Making decisions on dishonesty charges and the professional duty of candour'*, and to the NMC Code, in particular paragraphs 14, 15 and 16, which were applicable at the relevant time. The panel considered each underlying charge separately before reaching an overall conclusion.

Charge 1

The panel noted its earlier findings that Mrs Fayomi had acted dishonestly in relation to the 999 operator by creating the false impression that the Home had an AED. The panel was of the view that her conduct at the time lacked candour. The panel further noted that during the later investigation and disciplinary meetings, Mrs Fayomi did not provide a clear and open account, instead giving shifting explanations such as confusion, panic and misunderstanding. The panel considered that she was defensive and did not fully acknowledge what had occurred.

The panel also considered that had a safeguarding concern about this incident not been raised by the 999 operator, the incident would not have come to light as Mrs Fayomi had made any form of report or record about incidents surrounding Resident A on the night of 24 February 2019.

Charge 2

The panel noted that the risk assessment and care plan clearly required Resident B to be turned every two hours. Despite this, the panel found that Mrs Fayomi failed to ensure the required care was provided. The panel considered that her explanations changed over time, including saying she had turned the Resident twice, suggesting others should have assisted, and referring to being busy with medications. The panel also noted that Mrs Fayomi openly admitted in her disciplinary meeting with Ms Oxley that she had lied about turning Resident B every two hours in her investigation meeting with Mr Whibley.

In contrast, the panel noted that Ms King in her investigatory interview was clear and consistent that Mrs Fayomi did not undertake or assist with turning Resident B. Moreover, if Ms King had not brought this to the attention of her manager this omission in care may never have come to light.

The panel was of the view that these inconsistent explanations showed a failure to be open and transparent about the omission.

Charge 3

The panel noted that Mrs Fayomi accepted applying two pads and accepted attempting to use the hoist, but sought to justify or minimise both matters. In relation to the hoist, she said it was only from the corridor to the room. In relation to double padding, she said others had done it before and would do so again. The panel considered that these explanations were dismissive and failed to demonstrate proper candour. The panel also noted that concerns were raised by colleagues who were sufficiently alarmed that they brought them to the attention of the managers immediately whereas Mrs Fayomi made no disclosure at all as outlined in section 14 to 16 of the Code.

Charge 4 (a-e)

The panel noted that Resident D had suffered an unwitnessed fall and that Mrs Fayomi failed to carry out the required checks. The care plan and her training made clear what steps should follow a fall, including checks for injury, pain, head injury and vital signs.

During the investigation, Mrs Fayomi gave defensive explanations and sought to justify why she had not taken the appropriate action. The panel was of the view that she did not show openness about the seriousness of the incident, nor did she raise the matter herself despite the risks involved and the availability of senior staff on duty.

Having considered all of the evidence, the panel determined that Mrs Fayomi repeatedly provided inconsistent and self-serving explanations in relation to Charges 1 to 4, rather than giving a full and honest account of her conduct. The panel concluded that this behaviour amounted to a breach of the professional duty of candour, as she failed to be open and truthful about matters affecting resident care and patient safety. Accordingly, the panel found Charge 5 proved on the balance of probabilities.

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 Mrs Fayomi'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, Mrs Fayomi's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Welsh identified the specific, relevant standards where Mrs Fayomi's actions amounted to misconduct. Ms Welsh submitted that Mrs Fayomi's actions fell seriously below the standards expected of a registered nurse. It was her duty to provide safe, kind and effective care to vulnerable residents and to maintain trust in the profession.

Ms Welsh submitted that the findings showed serious failures in several areas of practice. These included poor clinical care, failures in communication during an emergency, not following care plans, unsafe moving and handling, and failing to respond properly after a resident had fallen. She said these were not minor errors, but matters that created a risk of harm to residents.

Ms Welsh further submitted that the findings of dishonesty were particularly serious. She said honesty is a fundamental tenet of the nursing practice. She submitted that Mrs Fayomi deliberately created the false impression that the Home had an AED during a medical emergency, which could have affected the response to Resident A.

Ms Welsh also submitted that Mrs Fayomi breached the professional duty of candour. She said Mrs Fayomi gave inconsistent explanations, failed to be open about what had happened, and sought to conceal her actions. For those reasons, Ms Welsh invited the panel to find that the conduct was serious misconduct.

Submissions on impairment

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

and Grant [2011] EWHC 927 (Admin) and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Welsh submitted that Mrs Fayomi's fitness to practise is currently impaired on the grounds of public protection and also otherwise in the wider public interest. She said the panel should consider whether Mrs Fayomi can now practise safely, kindly and professionally.

On public protection, Ms Welsh submitted that Mrs Fayomi's actions placed several residents at unwarranted risk of harm. She referred to the emergency incident involving Resident A, the failure to turn Resident B in line with the care plan, the unsafe care of Resident C, and the failures following Resident D's unwitnessed fall. She said these incidents showed repeated concerns across different areas of practice.

Ms Welsh submitted there is a real risk of repetition because there was insufficient evidence of insight, reflection, remediation or strengthened practice. She said Mrs Fayomi had not fully accepted responsibility and had often blamed circumstances or others rather than recognising the seriousness of her own conduct.

On public interest, Ms Welsh submitted that public confidence in the nursing profession would be undermined if a finding of impairment were not made. She said the case involved multiple residents, serious clinical failings, dishonesty, and a breach of candour. Ms Welsh therefore invited the panel to find that Mrs Fayomi's fitness to practise is currently impaired on the grounds of public protection and also otherwise in the wider public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cohen* and *Grant*.

Decision and reasons 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.'*

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

The panel was of the view that Mrs Fayomi's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Fayomi's actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> > *1.1 treat people with kindness, respect and compassion*
> > *1.2 make sure you deliver the fundamentals of care effectively*
> > *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***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*
> > *3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.*
>
> ***8 Work cooperatively***

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
8.2 maintain effective communication with colleagues
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

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

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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

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
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

13 Recognise and work within the limits of your competence
To achieve this, you must:

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers, and
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly, and
15.3 take account of your own safety, the safety of others and the availability of other options for providing care.

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

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices
16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it considered each charge individually and assessed whether Mrs Fay's conduct fell seriously short of the standards expected of a registered nurse.

Charge 1

In relation to Charge 1(a), the panel found that Mrs Fayomi had a duty to provide appropriate emergency care to Resident A. She was the registered nurse on duty and

was responsible for responding to a deteriorating emergency situation. By providing incorrect information to the 999 operator, thus delaying the correct treatment to that resident and placing them at serious risk of harm. She failed in her duty to that resident. The panel considered this to be a serious departure from the standards expected of a registered nurse and amounts to misconduct.

In relation to Charge 1(b), the panel found that Mrs Fayomi was asked several times whether an AED was available and repeatedly gave incorrect assurances that Mrs Fayomi was going to get the AED and had done so, and had it in her possession. The panel found this to be protracted dishonesty and despite having the opportunity to do so, Mrs Fayomi did not correct herself. It considered that misleading another professional during a medical emergency, through repeated and deliberate false information, amounted to serious professional misconduct.

In relation to Charge 1(c), the panel found that there was a clear protocol in place for contacting emergency services and ensuring the relevant information was readily available. Mrs Fayomi failed to provide clear and accurate details about the resident's date of birth and the resident's DNAR status. This caused avoidable confusion and delay in a resident receiving appropriate emergency care which could have resulted in serious harm. The panel considered this to be serious professional misconduct.

In relation to Charge 1(d), the panel found that Mrs Fayomi failed to follow the instructions of the 999 operator, despite being trained and expected to cooperate in an emergency situation. Rather than assisting the resident appropriately, Mrs Fayomi failed to follow the operator's instructions on numerous occasions which resulted in a delayed and ineffective response to this life threatening emergency. Her actions aggravated the situation and put Resident A at significant risk of harm. The panel considered this misconduct.

In relation to Charge 1(e), the panel found that Mrs Fayomi left Resident A during a life-threatening emergency in order to attend to another resident who did not require an urgent help. As the registered nurse on duty, she should have remained with the critically unwell resident that appeared to need resuscitation and asked another

colleague to attend to the less urgent resident. The panel concluded that Mrs Fayomi had effectively abandoned Resident A who was in a life threatening situation. The panel considered this conduct was genuinely deplorable and a serious falling short of expected standards amounting to misconduct.

In relation to Charge 1(f), the panel found that Mrs Fayomi's dishonesty was deliberate, repeated, and continued over a period of time of three phone calls to 999. She was trained and knew both the significance of providing precise and correct information and the potential consequence of deliberately providing misleading and untrue information in the midst of a life threatening emergency. This dishonesty delayed a resident's emergency treatment in a critical situation and put them at serious risk of harm. The panel considered the nature and seriousness of this dishonesty to amount to misconduct.

Taking all aspects of Charge 1 together, the panel found that the conduct amounted to serious professional misconduct.

Charge 2

The panel found that Resident B was an extremely vulnerable resident with existing pressure sores and there was a clear care plan stating she required repositioning every two hours, and she must be nursed side to side in bed and not on her back. Mrs Fayomi either failed to carry out these turns as described in the care plan either herself or ensure she delegated the task to a carer. The panel considered that this was fundamental nursing care and that failing to provide it placed the resident at significant risk of avoidable harm. This conduct amounted to serious professional misconduct.

Charge 3

In relation to the attempted use of the hoist, the panel found that Mrs Fayomi would have been trained in its safe and proper use. Despite this knowledge Mrs Fayomi sought to move Resident C in a wholly inappropriate manner placing both the resident's safety and dignity. The panel noted that it took a junior member of staff to intervene and stop her. As the registered nurse, Mrs Fayomi should have been setting the standard for safe practice. The panel concluded that Mrs Fayomi had attempted this transfer as a

matter of mere convenience for herself and in so doing exposed the resident to a completely avoidable risk and compromised their dignity. The panel determined that this conduct amounted to misconduct.

In relation to the application of two incontinence pads, the panel found that Mrs Fayomi placed her own convenience above the resident's needs and comfort. The panel was told by Ms Tajes that Resident C had passed large volume of urine and Mrs Fayomi applied two pads so she did not need to be changed as frequently. Ms Oxley reported that applying two pads to a resident is a form of abuse. She deliberately ignored concerns raised by junior staff at the time and failed to prioritise the resident's clinical needs and dignity. This amounted to avoidable harm to a resident and potential for further avoidable serious harm. The panel considered this to be grossly unacceptable care and found that it amounted to misconduct.

Charge 4

The panel found that there was a clear falls protocol in place to follow when residents fell and that Mrs Fayomi had received relevant training. Resident D also had care plan detailing the actions to take if they fell and advising all staff to follow the protocol for Barchester Management of Falls guidance Following Resident D's unwitnessed fall, Mrs Fayomi failed to carry out the necessary checks for injury, pain, head injury, or vital signs before moving the resident. Resident D was a particularly vulnerable resident with dementia, and there may have been an underlying medical reason for the fall, or serious injuries resulted from it. Mrs Fayomi simply disregarded the care plan and the required procedures, and in doing so put this resident at avoidable risk of harm.

The panel also found that the manner in which Mrs Fayomi pulled the resident by the wrists and moved the resident was wholly inappropriate, and lacked kindness and compassion and could have caused further avoidable injuries. This created a risk of further avoidable harm before any assessment had taken place.

The panel considered these failures to amount to serious professional misconduct.

Charge 5

The panel found that Charge 5 demonstrated a clear pattern of behaviour across a number of residents. Mrs Fayomi repeatedly failed to be open and honest about her actions and omissions. In each and every instance reports of disclosures about Mrs Fayomi's conduct came from external agencies as a safeguarding concern or more junior, non registered members of staff. Mrs Fayomi failed to record, report or notify any colleague or manager of any of these episodes where residents had been put at avoidable risk of harm. As a registered nurse Mrs Fayomi has a duty to be open and honest about her conduct and care, and any areas for improvement. She should be a reflective practitioner and learn from mistakes and this did not happen.

When concerns were later put to her, the panel found that Mrs Fayomi repeatedly gave inconsistent explanations, shifting accounts, sought to deflect blame, minimised her actions, and at times acted dishonestly. She justified some of her poor decisions by saying others performed tasks the same way. As a registered nurse Mrs Fayomi has a professional responsibility to challenge poor practice. The panel considered that this amounted to a blatant disregard of the duty of candour, which is a fundamental part of safe nursing practice and public confidence in the profession.

The panel considered that this pattern of behaviour was indicative of a deep-seated attitudinal concern. It found that Charge 5 amounted to misconduct.

Having considered all of the facts found proved, the panel was satisfied that Mrs Fayomi's actions fell seriously short of the conduct and standards expected of a registered nurse and therefore amounted to misconduct.

Decision and reasons on impairment

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

The panel recognised that it had limited information of Mrs Fayomi's current circumstances. The panel was mindful that these matters date back to September 2019 and that Mrs Fayomi in the intervening period has been employed in two care homes up

until February 2021. Since that time Mrs Fayomi has made contact with the NMC via telephone in which she has asserted that she is no longer in practice as a registered and she has advised that she has been removed from the Disclosure and Barring Service (DBS) and has not worked since.

The panel considered whether Mrs Fayomi can currently practise kindly, safely and professionally. The panel also considered whether her misconduct showed that she had in the past, or is liable in the future to, put residents at unwarranted risk of harm, bring the nursing profession into disrepute, breach fundamental tenets of the profession, and act dishonestly.

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

> *'Determining whether someone is fit to practise means that we have to consider whether the charges about the professional's practice which have been found proved:*
>
> - *engage one of these types of concerns and*
> - *indicate a continuing risk to:*
>   - *public safety,*
>   - *public confidence in their profession*
>   - *professional standards'*

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

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

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

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

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

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

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

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

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

The panel first considered the risk of harm caused by Mrs Fayomi's misconduct. In relation to Resident A, the panel found that Mrs Fayomi deliberately and intentionally gave incorrect information to the 999 operator about the availability of an AED, failed to

follow instructions, and abandoned the resident during a medical emergency to attend to a routine matter. Although the resident survived, the panel was satisfied that Mrs Fayomi's actions created a clear risk of avoidable serious harm in what was a life-threatening situation.

In relation to Resident B, the panel found that Mrs Fayomi failed to follow an established care plan for a frail and vulnerable resident with known skin integrity concerns. By failing to reposition the resident as required, she exposed that resident to an entirely avoidable risk of further injury and deterioration.

In relation to Resident C, the panel found that Mrs Fayomi attempted to move the resident in an unsafe manner using a hoist and was prepared to continue until another member of staff intervened. The panel also found that she used two continence pads for her own convenience rather than the resident's needs. The panel considered that this placed the resident at repeated risk of avoidable harm and compromised the resident's dignity.

In relation to Resident D, the panel found that after an unwitnessed fall, Mrs Fayomi failed to carry out appropriate checks detailed in their care plan before moving the resident and then moved the resident in an unsafe manner. The panel considered that in both regards Mrs Fayomi placed the resident in avoidable a risk of significant harm.

The panel also considered that Mrs Fayomi repeatedly failed to acknowledge errors, report incidents properly, or learn from her actions. In the panel's view, this showed a total disregard to residents' safety and significantly increased the ongoing avoidable risks to all residents. The panel therefore found that Mrs Fayomi had in the past put residents at unwarranted risk of harm.

The panel then considered whether Mrs Fayomi had brought the profession into disrepute. It determined that any reasonable member of the public, or fellow professional would view Mrs Fayomi's conduct as deplorable and wholly unacceptable. This included her handling of the emergency involving Resident A, her unsafe care of vulnerable residents, and her repeated omissions in care and failure to report incidents,

and learn from her mistakes. The panel considered that Mrs Fayomi’s care fell seriously short of the standards expected of a registered nurse and that her conduct would undermine confidence in the profession. The panel therefore found that Mrs Fayomi had in the past brought the nursing profession into disrepute.

The panel next considered whether Mrs Fayomi had breached fundamental tenets of the profession. The panel found that Mrs Fayomi’s misconduct involved repeated failures in basic nursing care, safeguarding, professionalism, honesty, integrity, accountability, and the duty of candour. These are central obligations of a registered nurse. The panel also noted that the misconduct was far from isolated. It involved several residents over a period of several months and demonstrated a repeated pattern of poor judgement and lack of professional responsibility. The panel therefore found that Mrs Fayomi had in the past breached fundamental tenets of the nursing profession.

The panel had already found that Mrs Fayomi acted dishonestly in relation to the charge concerning the emergency call and the information given about the AED. The panel also considered that a lack of candour and openness was a recurring feature of the case. Mrs Fayomi had given conflicting accounts in her investigation meetings about the care she provided and had repeatedly not admitted to her mistakes, putting residents at avoidable serious risk of harm. The panel therefore found that Mrs Fayomi had acted dishonestly in the past.

The panel then considered whether the concerns are capable of remediation, whether they have been remedied, and whether they are likely to be repeated. The panel accepted that some clinical failings, if isolated, may be capable of remediation through training, supervision and reflection. However, the panel considered that concerns involving dishonesty, lack of candour, repeated disregard of guidance, and attitudinal failings over several months are more difficult to remediate.

The panel found no evidence that Mrs Fayomi had taken meaningful steps to address the concerns. There was no evidence of insight, no reflective material, no clear acceptance of wrongdoing, no apology or remorse and no evidence demonstrating strengthened practice. Instead, the panel found that Mrs Fayomi had repeatedly blamed

others, changed her explanations, minimised her conduct, and failed to take any responsibility.

The panel considered that Mrs Fayomi had previously repeated unsafe conduct even after training and intervention from colleagues. In those circumstances, and in the absence of evidence of remediation, the panel concluded that there is a significant risk of repetition.

Accordingly, the panel concluded that not only the four limbs of *Grant* being engaged in the past, but that Mrs Fayomi presents a real risk in the future of placing patients at unwarranted risk of harm, bringing the profession into disrepute, breaching a fundamental tenet of the profession and acting dishonestly.

The panel concluded that a finding of current impairment is necessary to protect the public. In light of the serious and repeated nature of the misconduct, the lack of insight, the absence of remediation, and the significant risk of repetition, the panel determined that unrestricted practice would place public at real risk of harm.

The panel also considered the wider public interest, including the need to maintain confidence in the nursing profession and to uphold proper professional standards. It determined that public confidence in the profession and the NMC as its regulator would be seriously undermined if a finding of impairment were not made in a case involving repeated unsafe care of vulnerable residents, dishonesty, and lack of candour.

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

Sanction

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

this order is that the NMC register will show that Mrs Fayomi 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 had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Welsh reminded the panel that, since impairment had already been found, it now had to decide the right and proportionate sanction. She said the panel had the full range of sanctions available and should use the NMC sanctions guidance. In deciding the outcome, the panel must focus on protecting the public, maintaining confidence in the profession, and upholding proper professional standards.

Ms Welsh stated that there was one mitigating factor and that is Mrs Fayomi had no previous fitness to practise findings against her. However, Ms Welsh said that there were several serious aggravating features. These included placing vulnerable residents at risk of harm, a pattern of misconduct over time, poor clinical practice, failures in communication and decision-making, and dishonest behaviour. She said the misconduct was not isolated and continued even after supervision had been put in place.

Ms Welsh submitted that Mrs Fayomi had shown little or no real insight into her actions. She said Mrs Fayomi had denied wrongdoing, given inconsistent explanations, minimised concerns, and sometimes shifted blame onto others. In Ms Welsh's view, there had also been no meaningful remediation. Although time had passed since the incidents, she said Mrs Fayomi had not used that period to show what she had learned, how she had changed, or what she would do differently in the future.

In relation to the sanction the panel should consider, Ms Welsh submitted that taking no action, imposing a caution order, conditions of practice order, or a suspension order would not be sufficient to protect the public and address the wider public interest. She

said conditions would not address the deeper attitudinal and integrity concerns at the heart of this case, and suspension would not reflect the seriousness and repeated nature of the misconduct.

Ms Welsh submitted that only a striking-off order would properly protect the public, maintain confidence in the profession, and mark the seriousness of the dishonesty and failings found by the panel. She therefore invited the panel to impose a striking-off order.

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

Decision and reasons on sanction

Having found Mrs Fayomi’s fitness to practise currently impaired, the panel went on to consider what sanction, if any, should be imposed. The panel bore in mind that any sanction must be appropriate and proportionate. Although a sanction is not intended to be punitive, it may have that effect. The panel had careful regard to the Sanctions Guidance (“SG”). The decision on sanction was a matter for the panel, exercising its own independent judgement.

The panel first considered whether there were any mitigating factors. It determined that there were none. The panel considered whether Mrs Fayomi’s previous history, including the absence of any earlier regulatory findings, should be treated as mitigation. However, registered nurses are expected to practise to the standards set out in the Code and absence of any previous regulatory findings is not mitigation. It concluded that this did not reduce the seriousness of the misconduct found proved.

The panel also considered the workplace context put forward by Mrs Fayomi, but found that the evidence did not support the suggestion that wider workplace issues explained or excused her actions. The panel therefore did not accept that this amounted to mitigation.

The panel decided that the following aggravating features apply in this case:

- Mrs Fayomi was in a position of trust and abused that trust.
- There were deliberate breaches of the Code.
- There was a complete lack of insight into her failings and the risks created.
- There was a pattern of misconduct over a period of several months.
- Mrs Fayomi has not properly engaged with the regulatory process.
- The residents were extremely vulnerable because of their age, medical conditions, physical limitations and dependence on nursing staff.
- She failed to work collaboratively with colleagues.
- Her conduct put residents at risk of suffering serious harm.
- There was protracted dishonesty, including a breach of the duty of candour.

The panel considered the NMC guidance at SAN-4, which relates to the highest risk cases. It noted that dishonesty is treated particularly seriously, especially where it involves a breach of the professional duty of candour or creates a direct risk to those receiving care. The panel found that both of those features were present in this case. It also considered that the case involved neglect of highly vulnerable residents due to their age and the nature of their health conditions who were wholly dependent on nursing care.

The panel first considered whether to take no action. It concluded that this would be wholly inappropriate given the seriousness of the misconduct, the continuing public protection concerns, and the need to maintain confidence in the profession. The panel decided that taking no action would neither protect the public nor uphold proper professional standards.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Fayomi's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Fayomi's misconduct was not at the lower end of the spectrum and that a

caution order would be inappropriate in view of the seriousness of the case. The panel decided that a caution order would neither protect the public nor would it address the public interest issues identified.

The panel next considered whether a conditions of practice order would be sufficient and appropriate. It concluded that it would not. The misconduct in this case did not arise from a lack of clinical knowledge or skills alone. It also involved serious attitudinal concerns, disregard for professional standards, dishonesty, and failures of candour. These are not matters that can easily be remedied through retraining or supervision.

The panel also considered whether workable, measurable and enforceable conditions could be formulated. The panel concluded that they could not. Conditions may address technical shortcomings, but they would not adequately address concerns about integrity, judgement, willingness to follow guidance, or the risk of repeated dishonest behaviour. The panel also noted that previous training and retraining undertaken by Mrs Fayomi and this had not prevented her from repeating her failings. The panel concluded that further training would be unlikely to do so in the future. The panel was not satisfied that conditions would provide sufficient protection to vulnerable residents or maintain confidence in the profession. For those reasons, a conditions of practice order was appropriate. The panel further noted that Mrs Fayomi did not engage and has indicated that she does not wish to return to practice and in those circumstances conditions of practice order would not be workable.

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

- A single instance of misconduct but where a lesser sanction is not sufficient;
- No evidence of harmful deep-seated personality or attitudinal problems;
- No evidence of repetition of behaviour since the incident;
- The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;
- In cases where the only issue relates to the nurse or midwife’s health, there is a

risk to patient safety if they were allowed to continue to practise even with conditions; and

• In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.

The panel determined that none of these indicators are present in this case. This was not a single isolated incident. It involved repeated misconduct over time. There was evidence of deep-seated attitudinal concerns, dishonesty, and a disregard for professional obligations including a duty of candour. Mrs Fayomi had shown no insight, remorse, reflection, or remediation. A significant period of time had passed, yet no evidence had been provided to demonstrate learning or change. There was historic evidence of Mrs Fayomi having worked for short periods in two nursing homes in the months following the incidents. However, there no evidence of any reflection or learning from the previous incidents.

Mrs Fayomi also raised with the NMC in a telephone conversation dated 25 March 2026 that the DBS had removed her and she has not worked since. The panel has no further information about this available to it. The panel attached no weight to this.

The panel also considered whether a temporary period of suspension would realistically lead to safe unrestricted practice in the future. It concluded that there was no evidential basis for that conclusion. In the absence of insight or remediation, the panel considered there remained a real risk of repetition. It also found that a suspension order would not sufficiently mark the gravity of the misconduct or maintain public confidence in the profession and the regulator. Ultimately, the panel concluded that this was a case which raised fundamental concerns about Mrs Fayomi's compatibility to remain on the NMC register. Accordingly, the panel decided that a suspension order was not a sufficient, appropriate or proportionate sanction.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach

of the fundamental tenets of the profession evidenced by Mrs Fayomi’s actions is fundamentally incompatible with Mrs Fayomi remaining on the register.

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

> • *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
>
> • *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
>
> • *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mrs Fayomi’s actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Fayomi’s actions were serious and to allow her to continue practising would seriously undermine public confidence in the profession and in the NMC as the regulator.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

Having regard to the effect of Mrs Fayomi’s actions in bringing the profession into disrepute by adversely affecting the public’s view of how a registered nurse should conduct herself, the panel has concluded that nothing short of 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 decision will be confirmed to Mrs Fayomi in writing.

Interim order

As the substantive strike-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or is in your own interests until the substantive suspension order takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Welsh. She submitted that an interim suspension order is necessary to cover the period until the substantive strike-off order comes into effect having regard to the panel’s findings. She submitted that if Mrs Fayomi appeals the decision of the panel, then she would be able to practise without restrictions until the appeal process is finished and this can take up to 18 months. She therefore invited the panel to impose an order for a period of 18 months to cover the whole of the appeal period.

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

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be a suspension order, as to do otherwise would be incompatible with its earlier findings. The interim

suspension order will be for a period of 18 months to cover the appeal period and any appeal.

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

That concludes this determination.