Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Thursday, 28 May 2026

Virtual Hearing

Name of Registrant:	Abiodun Folasade Adejumo
NMC PIN:	03J0403O
Part(s) of the register:	Registered Nurse – Adult Nurse (10 October 2003)
Relevant Location:	Edinburgh
Type of case:	Misconduct
Panel members:	Peter Fish (Chair, Lay member) Corinne Foy (Registrant member) Michael Williams (Lay member)
Legal Assessor:	Caroline Hartley
Hearings Coordinator:	Tyra Andrews
Nursing and Midwifery Council:	Represented by Lindsay McFarlane, Case Presenter
Mrs Adejumo:	Present and represented by Christie Wishart, of Thompsons Solicitors
Order being reviewed:	Conditions of practice order (9 months)
Fitness to practise:	Not Impaired
Outcome:	**Order to lapse upon expiry in accordance with Article 30 (1), namely 10 July 2026**

Decision and reasons on review of the substantive order

The panel decided to allow the conditions of practice order to lapse on expiry.

The conditions of practice order will lapse upon expiry at the end of 10 July 2026 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the second effective review of a substantive conditions of practice order originally imposed for a period of 36 months by a Fitness to Practise Committee panel on 7 September 2022. It was scheduled to be reviewed on 15 September 2025 and 3 October 2025, but these hearings were adjourned. It was reviewed on 7 October 2025, and the panel imposed a further 9-month conditions of practice order.

The current order is due to expire at the end of 10 July 2026.

The panel is reviewing the order pursuant to Article 30(1) of the Order. The charges found proved which resulted in the imposition of the substantive order were as follows:

'That you, a registered nurse and registered manager of Standard Care Recruitment Limited ["Standard Care"]:

1) *Failed to ensure Care Manager X was registered with the Scottish Social Services Council ["SSSC"] appropriate to his role within six months of commencing employment.*

2) *In around January 2018, failed to take any or any appropriate action on learning the Disclosure Scotland was considering including Care Manager X on their adult's list.*

3) *Did not ensure one or more service users' care plans and/or care records were of adequate quality, in that:*

    a) *On an unknown date, there was no care plan included within Service User B's care folder;*

b) On one or more unknown dates, carers attending Service User D did not record:

i) The time their visit concluded,
ii) What care had been provided,
iii) When medication had been administered,
iv) Their full names, only marking their initials;

c) Service User D's records did not contain:
i) Personal details for Service User D,
ii) Emergency contact details,
iii) Details of Service User D's GP,
iv) Details of what needed to be completed on each visit.

4) Did not ensure adequate systems were in place to allow service users and/or their families to raise concerns about Standard Care directly with you.

5) Did not ensure staff were adequately trained to use and/or that they consistently used equipment required to care for service users, in that:

a) On an unknown date in around October 2018, Service User B's catheter was left closed; [in part]

b) On one or more occasions on unknown dates, carers pulled Service User B up by his armpits rather than using a hoist; [in part]

c) On around 1 September 2018, Service User D's son had to teach carers how to use the bath seat as she had not been given a bath for around 10 days;

d) On one or more occasion carers did not ensure Service User D was wearing her falls bracelet; [in part]

6) *Did not ensure carers followed advice or instructions of medication professionals in that in around October 2018 Service User B was moved from his bed against the instructions of his Marie Curie Nurses.*

7) *On or around 25 October 2018, following Care Manager X's dismissal, failed to promptly make a formal report of his misconduct to:*

   a) The Care Inspectorate;
   b) SSSC.

8) *On one or more of the following occasions, failed to ensure service users were visited by carers at their scheduled times or at all:*

a) On 26 October 2018 no carer attended Service User B;

b) On an unknown date in or around October 2018, no carer attended Service User B until 11:40pm;

c) On 25 October 2018, no carer attended Service User C;

d) …

e) On 16 August 2018, no carer attended Service User D for the morning visit;

f) On 29 August 2018, a carer attended Service User D:

i) At 2:49pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm,
ii) At 5:49pm for the dinner visit, which was scheduled between 6:00pm and 7:00pm;

g) On an unknown date, a carer attended Service User D at 3:14pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm;

h) On 31 August, carers attended Service User D at:

i) 9:15am for the morning visit, which was scheduled for around 8:00am,
ii) 2:24pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm,
iii) 4:47pm for the dinner visit, which was scheduled between 6:00pm and 7:00pm;

i) On 8 October 2018, a carer attended at 2:52pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm;

j) On 25 October 2018, no carer attended Service User D to assist with her bedtime routine;

k) On 26 October 2018 no carer attended Service User D for the first two scheduled visits of the day;

l) On 27 October 2018 no carer attended Service User D for the morning visit;

m) On 27 October 2018, Service User D was not attended to until 2:15pm;

n) On 27 October 2018, you did not attend the evening visit until 10:00pm;

o) On 28 October 2018, you was late attending Service User D;

p) On 29 October 2018, no carer had attended Service User D until 9:20pm;

q) On 26 October 2018, no carer attended Service Users E and F until 2:15pm;

r) On 25 October 2018, no carer attended Service User G's visit scheduled for 5:00pm until 9:35pm;

s) On 26 October 2018, no carer attended Service User G's visit scheduled for 9:30am until 10:40am.

9) Did not notify the care inspectorate of one or more of the late and/or missed visits to service users referred to in charge 8 above.

10) On or after 29 October 2018, did not follow the contingency plan when closing Standard Care.

11) Did not ensure you had unfettered access to:

a) Standard Cares' office

b) Care files of service users

12) Did not ensure you had adequate knowledge of the service provided by Standard Care to ensure patient safety.

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

The last reviewing panel determined the following with regard to impairment:

'The panel took into account the evidence of Witness 1 and the documentary evidence and concluded that you had not breached the conditions by working in a managerial position in any capacity during the life of the conditions of the practice order.

The panel accepted that you are a safe and competent nurse in your current Band 5 role and that there are no concerns regarding your clinical practice. However, the panel found that your fitness to practise remains impaired.

The panel took into account the documents that you have submitted, including the evidence of the training which you have undertaken, your reflective accounts, your testimonials, and the practice feedback. However, it noted that your reflective statement was largely a chronology of events and did not demonstrate sufficient insight into your accountability and professional responsibility as a registered nurse at the time of the incidents. The panel noted that your reflective statement had

failed to address how you would work differently, to ensure that proper systems were in place, to prevent the repetition of the poor management practice on your part that placed service users at risk of harm. It also noted that you have not shown full understanding of the potential risk to patients, the point at which you should have recognised that risk, or the actions you could have taken to prevent it.

The panel was of the view that while you have shown some insight and remorse, it concluded that you have not yet demonstrated a comprehensive understanding of your duty to safeguard patients and uphold professional standards in all settings. The panel concluded that there is a real risk of repetition and therefore it determined that a finding of current impairment remains necessary in order to protect the public.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.'

The last reviewing panel determined the following with regard to sanction:

'The panel next considered whether imposing a further conditions of practice order on your registration would still be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you have been complying with current substantive conditions of practice

The panel was of the view that a further conditions of practice order is sufficient to protect patients and the wider public interest. In this case, conditions could be formulated which would protect patients during the period they are in force.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response given the period of good practice since the last hearing and your journey towards reflection and insight.

For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. *You must not set up an agency or business that provides any nursing or care to clients.*

2. *You must not take on any new managerial nursing or care position that requires you to directly line manage other members of staff unless you are supervised by a line manager. In this situation, your supervision must consist of fortnightly meetings to discuss your managerial responsibilities. These should include (but are not restricted to):*

    - *your monitoring of your line reports' performance and capabilities*
    - *communication with relevant stakeholders to maintain patient safety*
    - *the effectiveness of any care plans that are completed by your team*
    - *upholding regulatory responsibilities as appropriate.*
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3. *If you are employed in any managerial role requiring you to directly line manage other members of staff, you must keep a reflective practice profile. The profile will:*

    - *Detail each line report for whom you are responsible*
    - *Set out the actions you have taken to ensure that your line report practises safely and effectively*
    - *Be signed by your own line manager each time*

- *Contain feedback from those who are your direct line reports on the effectiveness of the support you have given them in fulfilling their roles.*

4. *You must keep us informed about anywhere you are working by:*
    a. *Telling your case officer within seven days of accepting or leaving any employment.*
    b. *Giving your case officer your employer's contact details.*

5. *You must keep us informed about anywhere you are studying by:*
    a. *Telling your case officer within seven days of accepting any course of study.*
    b. *Giving your case officer the name and contact details of the organisation offering that course of study.*

6. *You must immediately give a copy of these conditions to:*
    a. *Any organisation or person you work for.*
    b. *Any agency you apply to or are registered with for work.*
    c. *Any employers you apply to for work (at the time of application).*
    d. *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*
    e. *Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.*

7. *You must tell your case officer, within seven days of your becoming aware of:*
    a. *Any clinical incident you are involved in.*
    b. *Any investigation started against you.*
    c. *Any disciplinary proceedings taken against you.*

8. *You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:*
    a. *Any current or future employer.*
    b. *Any educational establishment.*
    c. *Any other person(s) involved in your retraining and/or supervision required by these conditions.'*

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the Nursing and Midwifery Council ('NMC') has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel had regard to all of the documentation before it, as well as submissions from Ms McFarlane on behalf of the NMC and Ms Wishart on your behalf.

Ms McFarlane outlined the background of the case and the previous panel's decision. She acknowledged the positive steps you have taken since the previous hearing in relation to management training but submitted that there is little detail surrounding the contents of the course. Ms McFarlane further submitted that there is no evidence of how you are performing in mentoring and supporting situations. She invited the panel to consider that your insight is still developing. She submitted that it was a matter for the panel to consider whether continuation of the conditions of practice order would be appropriate and proportionate in the circumstances of this case.

Ms Wishart outlined the evidence provided including your reflective piece, positive testimonials and training certificates. She submitted that you have been compliant with the conditions of practice order and engaged with the NMC throughout. Ms Wishart further submitted that the high level of evidence shows that you are on an upward trajectory. She

stated that you have taken accountability, your insight has developed further and you have taken effective steps to maintain your skills and knowledge since the previous hearing.

Ms Wishart submitted that you have had a record of safe practice without further incident since 2022 with no further concerns raised whilst working in the same role. She stated that you are working as a band 5 nurse and are happy in the role insofar as that it is extremely unlikely that the circumstances of the original case will be repeated. Ms Wishart therefore invited the panel to find that your fitness to practise is no longer impaired and that the conditions of practice order should be lifted.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel noted that the last reviewing panel found that you have not shown full insight, and that your reflective piece '*failed to address how you would work differently, to ensure that proper systems were in place, to prevent the repetition of the poor management practice on your part that placed service users at risk of harm.'* Today's panel received a further reflective piece from you, in which you reflected deeply on what went wrong and how you would do things differently in the future. The panel considered that you have reflected deeply and have developed your insight significantly.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account the documentation you provided, which included:

- Your reflective piece
- Training list
- Standard Lead Auditor's Certificate 2019
- Testimonials from Ward Deputy Charge Nurse and mentored student nurse
- Care stories

The panel had regard to the documentation provided and was of the view that you had completed the relevant training courses and provided positive testimonials to reflect your strengthened practice. The panel noted your reflection regarding the training undertaken and considered this to comply with the conditions imposed and demonstrate a strengthened practice since the previous hearing.

The last reviewing panel determined that you were liable to repeat matters of the kind found proved. Today's panel noted that there is no evidence to suggest that concerns have been raised regarding your clinical practice over the period of four years. The panel further noted that there is no evidence that you have caused any harm to patients over the period of four years. The panel further noted that you are working as a band 5 nurse which is not a managerial role. It noted that you have advised you are happy in the role and do not intend to return to a managerial position.

In consideration of your strengthened practice through further training, positive testimonials provided and your developed insight, the panel determined that the risk of repetition is extremely low.

The panel has heard that you have complied with the conditions in place and you have reflected in depth regarding your previous failings without further incident raised. In light of this, this panel determined that you are now not liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is not necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance.

For these reasons, the panel finds that, although your fitness to practise was impaired at the time of the incidents, given all of the above, your fitness to practise is not currently impaired.

In accordance with Article 30(1), the substantive conditions of practice order will lapse upon expiry, namely the end of 10 July 2026.

This will be confirmed to you in writing.

That concludes this determination.