Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Wednesday, 20 August 2025 – Friday, 22 August 2025
Tuesday, 26 August 2025 – Thursday, 28 August 2025
Tuesday, 5 May 2026 – Wednesday, 13 May 2026

Virtual Hearing

Name of Registrant:	**Tolulope Edith Imoleayo Akeredolu**
NMC PIN:	12I1099E
Part(s) of the register:	Registered Nurse - Adult Nursing (15 March 2013)
Relevant Location:	London
Type of case:	Lack of competence
Panel members:	Susan Elizabeth Ball (Chair, registrant member) Mary Karasu (Registrant member) Katherine Richards (Lay member)
Legal Assessor:	Graeme Sampson (20 – 28 August 2025) Nigel Mitchell (5 – 13 May 2026)
Hearings Coordinator:	Adaobi Ibuaka Samara Baboolal (6 May 2026)
Nursing and Midwifery Council:	Represented by Elin Morgan, Case Presenter
Miss Akeredolu:	Present and represented by Lucy Chapman, Royal college of Nursing (RCN)
Facts admitted:	Charges 2b(iv)(3), 2c(i), and 2c(ii)
No case to Answer:	Charges 1(e), 2(b)(vi)(1), 2(b)(vi)(2), 2(b)(vii)
Facts proved:	Charges 1a, 1b, 1c, 1d(ii), 2a, 2b(i), 2b(ii)(1), 2b(ii)(2), 2b(iii), 2b(iv)(1), 2b(iv)(2) and 2b(v)

Facts not proved:	Charge 1d(i)
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim Suspension order (18 months)**

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

At the outset of the hearing, Ms Chapman made a request that this case be held partly in private on the basis that proper exploration of your case involves reference to your personal life and health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Morgan indicated that she supported the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session as and when references to your personal life and health matters are raised.

Details of charge

That you, a registered nurse:

1. Between 4 December 2017 and December 2019 whilst employed by Kings College Hospital NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    a. Failed medication competency assessments on the dates detailed in Schedule 1.

    b. Failed to successfully complete the capability action plans dated as per Schedule 2.

    c. On 8 March 2018, demonstrated poor infection control skills, in that you rinsed and then reused a tracheostomy catheter.

d. On 2 March 2018:

    i. Made inaccurate recordings of observations of a patient with spinal deficit.

    ii. Incorrectly completed Glasgow Coma Scale assessments/scores for a patient at the times as noted within Schedule 3.

e. In July 2019, failed to remove and/or replace the oxygen supply for an oxygen dependent patient which resulted in de-saturation.

2. Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    a. On 19 January 2021, failed to change a VAC collection canister.

    b. Demonstrated poor medications practice, in that you:

        i. On 14 April 2020, failed to follow the blood transfusion administration process and tractability.

        ii. On 19 April 2020, administered intravenous paracetamol to a patient in circumstances where:

            1. The patient was under the weight threshold to receive medication intravenously,

            2. The patient's prescription stated that they were to receive oral paracetamol.

        iii. On 7 May 2020, countersigned for a dose Oxycodone that was 10 times the prescription dose.

        iv. On 1 – 2 June 2020, during a night shift:

            1. administered intravenous Vancomycin at an incorrect rate.

            2. Recorded an incorrect concentration of Fentanyl on a patient's patient-controlled analgesia syringe.

3. Administered Glucojuice to a hypoglycaemic patient who had a Ryle's (nasogastric) tube in situ for a bowel obstruction.

v. On 15 June 2020, caused a delay in insulin administration for a patient who had elevated blood sugar.

vi. On 29 October 2020 failed to escalate a tachycardic patient whose cannula had been left in situ following discharge.

vii. On 27 March 2022, administered to a patient Hartman fluid, instead of the prescribed glucose.

c. Displayed poor infection control, in that you:

i. On 18 May 2020, disconnected and reconnected a patient's TPN and changed the settings in the middle of the infusion.

ii. On 28 January 2021, took down a patient's TPN without flushing the picc line.

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

Schedule 1:

- 04/01/2018
- 09/01/2018
- 28/03/2018
- 03/04/2018
- 01/05/2018

Schedule 2

- 25/01/2018

Schedule 3

- 11:01
- 15:02
- 19:14

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Morgan, on behalf of the NMC, to amend charge 2(b)(vi) by splitting it into two further charges.

The proposed amendment was to separate the charge into two separate sub charges. It was submitted by Ms Morgan that the proposed amendment would provide clarity and more accurately reflect the evidence.

The stem of the charge currently reads:

> ***"vi. On 29 October 2020 failed to escalate a tachycardic patient whose cannula had been left in situ following discharge."***

Proposed amendment as follows:

> ***"vi. On 29 October 2020:***
>
> 1. ***Failed to escalate a tachycardic patient***
> 2. ***Left a cannula in situ for a patient who had been discharged."***

The panel heard that Ms Chapman did not oppose the suggested amendments.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Details of charge (as amended)

That you, a registered nurse:

1. Between 4 December 2017 and December 2019 whilst employed by Kings College Hospital NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    a. Failed medication competency assessments on the dates detailed in Schedule 1.

    b. Failed to successfully complete the capability action plans dated as per Schedule 2.

    c. On 8 March 2018, demonstrated poor infection control skills, in that you rinsed and then reused a tracheostomy catheter.

    d. On 2 March 2018:

        i. Made inaccurate recordings of observations of a patient with spinal deficit.

        ii. Incorrectly completed Glasgow Coma Scale assessments/scores for a patient at the times as noted within Schedule 3.

    e. In July 2019, failed to remove and/or replace the oxygen supply for an oxygen dependent patient which resulted in de-saturation.

2. Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    a. On 19 January 2021, failed to change a VAC collection canister.

    b. Demonstrated poor medications practice, in that you:

        i. On 14 April 2020, failed to follow the blood transfusion administration process and tractability.

        ii. On 19 April 2020, administered intravenous paracetamol to a patient in circumstances where:

1. The patient was under the weight threshold to receive medication intravenously,

2. The patient's prescription stated that they were to receive oral paracetamol.

iii. On 7 May 2020, countersigned for a dose Oxycodone that was 10 times the prescription dose.

iv. On 1 – 2 June 2020, during a night shift:

1. administered intravenous Vancomycin at an incorrect rate.

2. Recorded an incorrect concentration of Fentanyl on a patient's patient-controlled analgesia syringe.

3. Administered Glucojuice to a hypoglycaemic patient who had a Ryle's (nasogastric) tube in situ for a bowel obstruction.

v. On 15 June 2020, caused a delay in insulin administration for a patient who had elevated blood sugar.

vi. On 29 October 2020:

1. failed to escalate a tachycardic patient
2. left a cannula in in situ for a patient who had been discharged

vii. On 27 March 2022, administered to a patient Hartman fluid, instead of the prescribed glucose.

c. Displayed poor infection control, in that you:

i. On 18 May 2020, disconnected and reconnected a patient's TPN and changed the settings in the middle of the infusion.

ii. On 28 January 2021, took down a patient's TPN without flushing the picc line.

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

Schedule 1:

- 04/01/2018
- 09/01/2018
- 28/03/2018
- 03/04/2018
- 01/05/2018

Schedule 2

- 25/01/2018

Schedule 3

- 11:01
- 15:02
- 19:14

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Morgan for an application to allow hearsay evidence on a number of exhibits under rule 31.

Ms Morgan made submissions that the following should be admitted as hearsay:

- Exhibit SAQ 3 – Ms Morgan submitted that this was a record of your development plan, that was put in place following your induction at the Trust 1. Ms Morgan further submitted that the author of that plan is not known but has multiple different authors who have signed their initials when they recorded something into the plan that the exhibit speaks to multiple different charges and so it's not the sole or decisive evidence for any of those charges. However, it is heavily referred to by Sarah Quinn (Ms Quinn)

- Exhibit SAQ 6 – Ms Morgan submitted that this is a handwritten statement of Monique Clark (Ms Clark), a healthcare assistant who stated that she witnessed you rinsing a catheter under non sterile running water before reusing it. This

evidence speaks namely to, charge 1c and is not the sole or decisive evidence in relation to that charge.

- Exhibit SAQ 8 – Ms Morgan submitted that this was your practise log from when you were at the Trust 1, and this was prepared by another nurse, Sarah Karen (Ms Karen). It refers to charge 1c, but she submitted that it is not the sole or decisive evidence in relation to that charge.

- Paragraphs 22 and 23 of the Sarah Quinn's (Ms Quinn) witness statements - Ms Morgan submitted that Ms Quinn described the events which make up charge 1e relating to the allegation that you removed the oxygen supply for a patient. Ms Morgan further submitted that the source of Ms Quinn's information provided is from a ward manager however that person is not named. She submitted that it was not the sole and decisive evidence in relation to that charge and that there was reference to it in exhibit SAQ 1.

- Exhibit AS/6 - Ms Morgan submitted that this was an e-mail from a member of staff Colleague D, who raised the concern of the charge in relation to 2b(iv)(3), whereby it is alleged that you administered Glucojuice to a patient who was Hypoglycaemic and had a Ryle's (nasogastric) tube in situ for a bowel obstruction. She submitted that this charge was admitted by you but denied in relation to exhibits AS/9 and AS/15.

- Exhibit AS/9 – Ms Morgan submitted that this was an e-mail from a member of staff, Laura Phillips (Ms Phillips), a band 6 nurse on the ward, which was sent to Ahsley Sartini (Ms Sartini). In this e-mail, Ms Phillips reports the issue to Ms Sartini, which is what forms charge 2b(vi)(a) and 2b(vi)(b).

- Exhibit AS/15 – Ms Morgan submitted that this was an email from Kelsey Gurney (Ms Gurney) describing a meeting that took place after the facts of charge 2b(iii), where it was alleged that you countersigned oxycodone in error.

Ms Morgan submitted that there are adequate witnesses that can be cross examined in this case, and both witnesses called represented each trust. She submitted that these witnesses may not have been present at the time of each individual alleged incident, but they were in positions where they could make statements about what has happened for all of the incidents.

Ms Morgan submitted that Ms Quinn was the matron covering your ward at the Trust 1 and Ms Sartini, was one of your line managers and the ward sister at the Trust 2.

Ms Morgan drew the panels attention to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and *Ogbonna v Nursing and Midwifery Council* [2010] EWHC 272 (Admin) which provided 7 specific considerations for a panel in regulatory proceedings to consider.

1. Whether this is the sole and decisive evidence supporting the charges against you. Ms Morgan submitted that the evidence highlighted are not the sole and decisive evidence supporting the charges against you.
2. What are the nature and extent of the challenge to the reliability and accuracy of the witness statements. Ms Morgan submitted that that the evidence speaks to your time at both trusts and would not be something that would be opposed per se.
3. The extent and nature of the challenge to the reliability and accuracy of whether there was evidence to suggest that the witnesses had reasons to fabricate evidence. Ms Morgan submitted there has not been, however, did acknowledge that in relation to the e-mail from Maia (Ms Maia) it is not clear who she is.
4. Seriousness of the charge and potential impact of adverse findings on your career.

5. Reason for non-attendance of witnesses, to which Ms Morgan submitted that there is good reason not to call all the witnesses listed in the evidence as it would not be proportionate to call all of these professional people to give evidence given the fact that this is a competency case.
6. Steps to secure attendance of the witnesses, to which Ms Morgan submitted the NMC has done for Ms Quinn and Ms Sartini.
7. Prior notice of witness statements being read as evidence, to which Ms Morgan submitted you were given.

For these reasons, Ms Morgan submitted that the panel should admit the proposed exhibits pursuant to Rule 31 of the fitness of practise rules.

Ms Chapman opposed the application to admit the evidence listed as hearsay. She submitted that under Rule 31 it's accepted most of the evidence is relevant to the charges. but it would not be fair to admit it as the evidence both in the exhibits and in the witness statements rely on information purported from another person/s who have not been called as witnesses. Ms Chapman submitted that there is a fundamental need for fairness in this case and the evidence highlighted would not give you a fair trial as you will not be able to cross examine the witnesses mentioned in the evidence.

Ms Chapman invited the panel to consider the factors set out in the case of Thorneycroft and the case of *El Kharout v The Nursing and Midwifery Council* EWHC 28 (Admin).

Ms Chapman submitted that the following:

- Exhibit SAQ3 and SAQ6 - Ms Chapman submitted that this document is from a staff member that alleges that a complaint has been made by someone else who is not known, Ms Clark. Ms Clark also provided the exhibit SAQ6, to which Ms Chapman further submitted that neither are witnesses called by the NMC and this is the sole and decisive evidence for charge 1c.

- Exhibit SAQ8 - Ms Chapman submitted that the evidence in this exhibit is inadmissible hearsay, it is referred to in paragraphs 19 of Ms Karen statement who is not an NMC witness. She submitted that it is sole and decisive evidence and that most of the matters within this exhibit is disputed, therefore, inaccurate and unfair to allow this document in as evidence.

- Paragraphs 22 and 23 of the Ms Quinn's witness statements - Ms Chapman submitted is sole and decisive evidence for charge 1e, is the most serious charge due to the nature of the situation being life or death, and it stands out from the other charges. Ms Chapman submitted that there is no way to test or know reliability of the source of the evidence as it has not been identified and happened a long time ago.

- SAQ1, Paragraphs 4-5, 14, 15, 22-24 - Ms Chapman submitted are all hearsay that should not be admitted as it is not clear who the information has come from and would be unfair to rely on this.

- Exhibit AS/9 - Ms Chapman submitted that it is the sole and decisive evidence relating to charges 2b(vi)(1) and 2b(vi)(2) which are both denied by you.

- Exhibit AS/12 - Ms Chapman submitted paragraph 78 should be redacted if this evidence is excluded by the panel.

- Exhibit AS/15 - Ms Chapman submitted that it should be removed in its entirety. She submitted that it relates to an email from Ms Gurney who is not an NMC witness and you admit that you did co-sign the wrong dose and not that the dose was administered. Ms Chapman further submitted that the suggestion of an overdose in not supported by contemporaneous clinical documentation and Ms Quinn did not witness this but was told about it from another person, furthermore, it does not align with what is in Ms Quinns statement.

Ms Chapman submitted that in light of all the above, you could not have a fair trial where the evidence highlighted is admitted to and that there is absolutely no reverse burden on you. She further submitted that it is for the NMC to bring and prove its case against you and to comply with Rule 31 especially in regards to relevance and fairness.

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

The panel decided to accept the NMCs application for the specified evidence to be admitted as hearsay evidence.

The first group of items of evidence asserted to be inadmissible hearsay relate to charge 1c, concerning poor infection control skills. In regards to paragraphs 14 and 15, the first sentence of paragraph 16 and 20 which are found in SAQ3 and SAQ6, the panel considered that the note was written by Ms Clark who is described as the ward manager and not a health care assistant (HCA).The HCA allegedly witnessed something you had done and reported it to Ms Clark who wrote it down and reported it to Ms Quinn. Therefore, the panel considered that this showed demonstrable reliability because Ms Clark is a senior professional and the panel formed the view that Ms Clark had no reason to fabricate the evidence. The panel decided that the evidence is admissible, although Ms Clark is not called as an NMC witness. Ms Clark had a professional duty to record such a serious allegation. The evidence in relation to this allegation can be tested.

It is not the sole and decisive evidence for this charge. The panel was made aware that there had been other allegations of a lack of infection control measures and that this had been recorded in exhibit SAQ8.

The second group of items of evidence asserted to be inadmissible hearsay relate to charge 1e, failure to properly manage the patient's oxygen supply. The evidence complained of arise in paragraphs 6, 22, and 24 of the witness statement of Ms Quinn. The panel did consider whether it was the sole and decisive evidence. It noted that it may look like hearsay but also may not necessarily be hearsay, as one cannot tell from the

language used whether the witness was present at the events recorded. Therefore, the panel were of the opinion that this should be admitted into evidence and can attach the appropriate weight to it when the panel hears from Ms Quinn.

The third group of items of evidence relate to charge 1d(i) and inaccurate recordings for a patient with a spinal deficit. As regards to the complaints of hearsay in paragraph 24 of Ms Quinn's witness statement, the panel noted that you had already partially admitted to this charge in relation to the inaccurate recording and this evidence speaks to the admitted charge and is therefore not the sole and decisive evidence.

In regards to paragraph 4-5 and exhibit SAQ1, the panel considered that Ms Quinn refers to this in her witness statement. Exhibit SAQ1 records a conversation with Ms Quinn and the NMC. The panel noted that Ms Quinn will be able to speak to this and the panel will then apply the appropriate weight to the evidence after Ms Quinn's live evidence.

The fourth group of items of evidence relate to charge 2b(iii) and the erroneous recording of the oxycodone dose. In regards to paragraph 9 of the witness statement of Ms Sartini and exhibit AS/15, the panel considered that this evidence was not hearsay evidence as it was admitted by you, pertaining to countersigning the oxycodone. The panel further considered that the evidence is not sole and decisive and can be easily tested by asking you during your live evidence, to which the panel could then make a decision on the facts.

The fifth group of items of evidence relate to charge 2b(vi) and relates to a lack of escalation and failure to remove a cannula prior to discharge. In regards to paragraph 17 of witness statement of Ms Sartini and exhibit AS/9, the panel considered that the contents of the email could be hearsay but were of the opinion that this is something they could question Ms Sartini about in her live evidence.

Considering all of the circumstances, the panel concluded that it would be fair and reasonable to admit the specified evidence as hearsay evidence.

Background

You were first referred to the NMC on 25 January 2020 by the Kings College Hospital NHS Foundation Trust (the Trust 1). Concerns were raised as you had been on a capability and performance management plan due to concerns around your medication safety, neurological assessment and observations, and professionalism in the workplace. You had been receiving support from the Trust 1 since 2018. Enquiries undertaken with the Trust 1 identified further potential concerns in respect of your health. You resigned from your post as a Band 5 nurse with the Trust 1 on 18 November 2019 whilst your capability programme was ongoing.

You subsequently gained employment with Guys and St Thomas' NHS Foundation Trust (the Trust 2).

The NMC was informed by the Trust 2 in February 2020 that they had concerns regarding your practice, specifically communication/attitudinal issues, undertaking a task without having completed the competencies required and poor management of an implanted vascular access device. The NMC was then advised of subsequent concerns which allegedly took place between May 2020 and June 2020. These concerns related to your ability to administer medication. As a result, you were placed on a performance improvement plan for 4-6 weeks, following which you were involved in multiple further incidents, most of which were clinical. Considering the new incidents and following a capability review meeting on 31 March 2021, the Trust 2 informed you that they would be proceeding to the second stage of their Capability Policy and Procedure. Further incidents occurred on 27 March 2022 and 9 April 2022 which resulted in the Trust 2 beginning a formal disciplinary process against you. A further medication issue was reported to the NMC in September 2022 and the Trust 2 confirmed in November 2022 that you had been demoted to a nursing assistant role. You left the Trust 2's employment on 23 May 2023.

Decision and Reasons on application of no case to answer

Ms Chapman, at the close of the NMC's case, made an application that there was no case to answer in relation to charges 1b, 1c, 1e, 2b(vi)(1), 2b(vi)(2), and 2b(vii). Ms Chapman referred the panel to the case of *R v Galbraith* [1981] 1WLR 1039 and NMC Guidance DMA-6. She submitted that there is insufficient evidence to find the facts proved. This application was made under Rule 24(7).

Charge 1b:

In relation to Charge 1b, Ms Chapman submitted in paragraph 35 of Ms Quinn's witness statement, she stated that she did not know whether or not you had completed the action plan, and this was accepted by Ms Quinn in her oral evidence. Ms Chapman referred the panel to the bottom of page 15 of the Staff record of the contact/facilitation with Practice Development Nurse (PDN) document, dated 4 December 2017, which stated that the action plan was completed and successful. Therefore, Ms Chapman submitted that there was no evidence to support this charge.

Charge 1c:

In relation to charge 1c, Ms Chapman submitted that there is some evidence for this charge, however, when taken at its highest, it could not properly result in the fact being found proved. She referred the panel to paragraph 14 and paragraph 15 of Ms Quinn's witness statement and paragraphs 16 and 20 of the Staff record of contact/facilitation with PDN document and the Health Care Assistant statement dated 5 March 2018, written by Ms Clark.

Ms Chapman referred to the panel's earlier decision to accept the hearsay evidence that shows the original allegation came from an unnamed Health Care Assistant (HCA), which was reported to the ward manager, Ms Clark who relayed this to Ms Quinn. Ms Chapman submitted that neither the HCA nor Ms Clark was called as witnesses for this hearing. She further submitted that although the panel noted Ms Clarks position as to a reason she

would likely not fabricate anything and was demonstrably reliable, Ms chapman submitted that even professional people make mistakes or could relay what they were told wrongly.

Ms Chapman submitted that the panel has not, in its hearsay determination, stated how it would know that the anonymous allegation made by a HCA, which was repeated in Ms Clark's statement, was reliable. She further submitted that the panel could not know it was reliable, as the report is from an unknown person and therefore there is no way of knowing what they actually saw. Ms Chapman referred the panel to *White v Nursing and Midwifery Council* [2014] EWHC 520 (Admin), stating this not only applies when considering the admissibility of anonymous hearsay evidence, but also to the reliance on it to prove facts.

Therefore, Ms Chapman submitted to the panel that no weight should be attached to the evidence which supports this charge. The evidence is tenuous, and it would not be safe to rely upon it.

Charge 1e:

Ms Chapman submitted that there is some evidence for this charge, however, when taken at its highest, it could not properly result in the fact being found proved. She referred the panel to paragraphs six, 22 and 24 of Ms Quinn's witness statement and the 'Staff record of contact/facilitation with PDN document' dated 22 October 2018 –10 December 2018. Ms Chapman referred to the panel's decision on hearsay in regards to this document and submitted that in Ms Quinn's oral evidence, it was made clear that this was multiple anonymous hearsay evidence.

Ms Chapman submitted that Ms Quinn was the only witness to speak to this charge and did not know any details about what was alleged to have happened during this incident. She further submitted that Ms Quinn did not know who allegedly witnessed this and did not know who reported it to the ward manager. Ms Chapman submitted that Ms Quinn stated in her oral evidence that the concern wasn't that the tube had been removed but that you were allegedly going to leave the room without changing the oxygen. She

submitted that it was an anonymous person who reported this and there is no evidence as to how they knew/suspected that you were going to leave that room.

Ms Chapman submitted that based on those factors, there is not sufficient evidence to support this charge.

Charge 2b(vi)(1) and 2b(vi)(2):

Ms Chapman addressed the panel on the two charges together and submitted that the evidence was too tenuous for the panel to rely upon for the facts to be found proved.

Ms Chapman submitted that the only evidence for these charges comes from paragraph 17 of the witness statement of Ashley Sartini (Ms Sartini), where she exhibits a hearsay email from Ms Philips, dated 12 January 2021.

Ms Chapman referred to the panel's hearsay determination and submitted that Ms Sartini clarified in her oral evidence that this was hearsay material and it was not witnessed by her, and that her knowledge of the alleged incidents was very limited. She further submitted that Ms Sartini agreed that there would have been a Datix completed had these alleged incidents occurred, to which you would have been asked to complete a reflection of them, but there is no evidence of that.

Therefore, Ms Chapman submitted that the entirety of these charges relies more on mere assertion from a hearsay document and there is not sufficient evidence to support these charges.

Charge 2b(vii):

Ms Chapman submitted that there was no evidence to support this charge and referred the panel to paragraph 21 of the witness statement of Ms Sartini, where this allegation stems from.

Ms Chapman submitted that it has become apparent from the evidence that this was not something Ms Sartini had witnessed and it was anonymous hearsay. She submitted that the exhibit relied upon for this charge was the Intravenous Insulin or frequent glucose monitoring chart. She submitted that it was established in cross-examination of Ms Sartini that your name and initials were not on the chart, and therefore there was no evidence that you were involved.

Ms Chapman further submitted that Ms Sartini, in her evidence-in-chief, was asked how she could tell Hartmann fluid was administered instead of glucose, to which she responded that at this time she did not have access to the medication chart that would have been used.

Ms Chapman submitted that there was no direct evidence or supporting evidence of a patient being administered Hartmann Fluid instead of glucose or that you were responsible for that. Therefore, there is no evidence to support these charges.

The panel then heard submissions from Ms Morgan on the application for no case to answer in relation to charges 1b, 1c, 1e, 2b(vi)(1), 2b(vi)(2), and 2b(vii).

Charge 1b:

Ms Morgan referred the panel to the dates under schedule 2 in the schedule of charges, specifically 25 January 2018. She submitted that from looking at the evidence, it is clear to see that the 25 January 2018 refers to the informal action plan, which was initially put in place, and is also referenced in the ‘Staff record of contact/facilitation with PDN document’. She further submitted that it describes a four-week plan starting on the 25 January 2018 and should be completed on the 22 February 2018.

Ms Morgan submitted that this evidence is supported by the inputs on the table of that exhibit around the time of 22 February 2018 and is further supported by the need to put you on a formal action plan on both 3 April 2018 and 11 April 2018.

Ms Morgan submitted that Ms Quinn in her evidence stated that your improvements were inconsistent and needed to be consistent for the action plan to be passed. She further submitted that the action plan you did complete was the subsequent formal plan, which was put in place as a result of the 25 January 2018 capability action plan not being passed.

Charge 1c:

Ms Morgan submitted that there is some evidence in relation to this charge when taken at its highest.

Ms Morgan submitted that the matter was directly reported to Ms Clark who discussed this with you in a meeting on 8 March 2018, to which you denied doing. She submitted that, as a result, you were taken off night shifts and were asked to think about what other areas you may be needing additional support in.

Ms Morgan submitted that the panel have already made their decision on hearsay and they should stay true to that decision, and in due time, place the appropriate weight on the hearsay evidence.

Charge 1e:

Ms Morgan submitted that there is some evidence in relation to this charge when taken at its highest. She submitted that Ms Quinn did not see the alleged incident. However, during Ms Quinn’s evidence-in-chief, she stated that constant oxygen was required for this patient.

Ms Morgan submitted that, although Ms Quinn could not say how long the oxygen was disconnected, it was long enough for the member of staff, who was with you at the time, to be concerned that the patient could become unwell. Ms Morgan accepted that the charge did not state a length of time that the oxygen was disconnected.

Charge 2b(vi)(1):

Ms Morgan reminded the panel that this charge was originally one charge, but was split into two. She submitted that in evidence it is stated that you did in fact raise that the patient in question was tachycardic. However, you failed to appreciate the severity of this, and failed to escalate appropriately.

Ms Morgan submitted that, when asked what is expected of a nurse, Ms Sartini responded, *"I would expect that a nurse complete an ECG, report to doctors, let the nurse in charge know and consider what things could be driving the heart rate, for example, sepsis, dehydration etc."*

Charge 2b(vi)(2):

Ms Morgan referred the panel to an email from the Band 6 nurse, Ms McPhillips, who raised this. She submitted that although she completed this email two and a half months after the event, her memory of it was good as she recalls the dates, the numbers in relation to the tachycardic patient and even the conversation she had with you and also that the patients granddaughter was very upset with the incident.

Ms Morgan submitted that when she asked Ms Sartini who was responsible for ensuring that a patient is ready for discharge, she stated that the nurse and nurse in charge are jointly responsible, to which Ms Morgan submitted included you.

Ms Morgan submitted that it is not the NMC's case that you are solely responsible for this. However, the charge encapsulates that you certainly held some responsibility in ensuring that the canula was removed prior to discharge.

Charge 2b(vii):

Ms Morgan submitted that in paragraph 21 of Ms Sartini's witness statement, she stated it was glucose that was prescribed for the patient, not Hartmann fluid. Ms Sartini went on to say that she was not sure why you administered the Hartmann fluid. Ms Morgan further submitted that this was also checked by another nurse who was equally culpable, but that the presence of another nurse who checks it does not take away from the responsibility you had to administer the correct medication.

The panel took account of the submissions made and accepted the advice of the legal assessor.

In reaching its decision, the panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer. The panel had regard to the relevant legal test for determining an application of no case to answer which is set out in *R v Galbraith* [1981] 1 WLR 1039 and endorsed in the NMC's guidance (DMA-6).

Decision and reasons on application to amend the charge

During the course of its deliberations, the panel noted that charge 1(c) appeared to contain the wrong date and did not specify that it was a suction catheter that was being used.

The panel considered amending the wording of charges 1c to reflect this, as this would provide clarity and more accurately reflect the evidence. The panel sought representations from Ms Chapman and Ms Morgan in respect of its application.

Ms Morgan submitted did not oppose amending the date of this charge. In relation to the suction catheter, it is initially described as a tracheostomy catheter in Ms Quinn's statement, and from then onwards the two terms (suction catheter and tracheostomy catheter) are used interchangeably. She submitted that it may be unnecessary to amend the wording in this respect.

Ms Chapman submitted that she did not oppose the date of the charge being changed, as your position is that you deny the charge. Ms Chapman agreed with the submissions made by Ms Morgan.

The panel accepted the advice of the legal assessor.

The panel determined that it would make clear in its determination on facts as to the type of catheter being used on the 5 March 2018. The panel therefore decided to only amend the date.

The charge now reads:

> ***"1.*** *Between 4 December 2017 and December 2019 whilst employed by Kings College Hospital NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:*
>
> > ***c.*** *On ~~5~~8 March 2018, you on how demonstrated poor infection control skills, in that you rinsed and then reused a tracheostomy catheter**."***

Decision and reasons on no case to answer

Charge 1b:

The panel considered the evidence before it and noted that you were given an informal action plan dated 25 January 2018 and needed to complete this by 26 February 2018. The actions required to improve performance and success criteria, stipulated in the 25 January 2018 action plan were duplicated in the action plan of 3 April 2018. This indicates that these were not achieved by the 26 February 2018. Therefore, the panel determined that there was sufficient evidence to support charge 1b.

Charge 1c:

The panel considered the evidence before it including: the Staff record of contact/facilitation with the PDN document dated 4 December 2017, and the Health Care Assistant report dated 5 March 2018, written contemporaneously by Ms Clark. The panel noted that on 5 March 2018, it was reported by the HCA to Ms Clark that you had suctioned a patient, and that the technique you used was not what the HCA had observed other nurses using. This concern was raised with you by the PDN on 8 March 2018, and as a result, you were then booked onto a tracheostomy study day on 27 April 2018. The panel further noted that on page 7 of the statement of the HCA statement written by Ms Clark and in paragraph 14 of Ms Quinn's witness statement, there is reference to you using a suction catheter. Ms Quinn's evidence was that you had demonstrated poor infection control when using a suction catheter.

Therefore, the panel determined that there is sufficient evidence to support this charge.

Charge 1e:

The panel considered the evidence before it and noted that Ms Quinn, in oral evidence, stated that in the circumstances, if this incident had taken place, there should have been a Datix and a reflection completed. However, Ms Quinn could not provide Datix or reflection.

The panel also considered that Ms Quinn had stated that she was not concerned about whether or not the tube had been removed, but whether you had left the room without replacing the oxygen. The charge alleges that you failed to remove and/or replace the oxygen supply. There is no evidence that you failed to remove the oxygen supply. Whilst you may have had a duty to replace the oxygen supply, the circumstances surrounding this alleged incident are not clear. Further, there is no reliable documentary evidence to show that the patient suffered desaturation.

In all the circumstances, the panel determined that the evidence in respect of this charge was confusing, with one witness being more concerned about whether you were going to leave the room without turning the oxygen back on, than what was taking place in the room.

Therefore, the panel determined that there is insufficient evidence to support this charge, and there is therefore no case to answer.

Charge 2b(vi)(1) and 2b(vi)(2):

The panel considered each of these charges separately.

The panel considered the evidence before it, and noted Ms Sartini's evidence that a Datix would have been completed had these incidents occurred and a reflection would have had to be written by you as well. The panel noted that it had no such information before it, and noted that the only evidence in relation to these charges was the evidence of Ms Sartini, who told the panel that she had not witnessed this alleged incident and that her knowledge of it was limited. Further, the panel was not provided with any clinical evidence that a patient was tachycardic. The panel also noted that it did not have any information as to who the patient/s was/were and there was no evidence before it to suggest that you were responsible for the discharge of the patient.

Therefore, the panel determined there was insufficient evidence to support these charges, and found no case to answer in respect of charge 2b(vi)(1) and 2b(vi)(2).

Charge 2b(vii):

The panel considered the evidence before it and had sight of the Intravenous Insulin and frequent glucose monitoring chart. The panel noted that there was evidence in the chart to show that glucose was prescribed on 27 March 2022 and nothing to show that Hartmann's fluid had been prescribed or administered. There was no indication on the charts that you had signed or had any involvement with administering the intravenous fluids.

Therefore, the panel determined there was insufficient evidence to support this charge and found no case to answer in respect of charge 2b(vii).

The panel was therefore of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charges 1e, 2b(vi)(1), 2b(vi)(2) and charge 2b(vii), proved. The panel therefore found no case to answer on these charges.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Chapman, who informed the panel that you made full admissions to charges 2b(iv)(3), 2c(i), and 2c(ii)

The panel therefore finds charges 2b(iv)(3), 2c(i), and 2c(ii) proved in their entirety, by way of your admissions.

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

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

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

- Witness 1: Matron at Trust 1
- Witness 2: Ward Sister at Trust 2.

The panel also heard live evidence from you.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and you.

The panel also bore in mind your good character, noting that there have been no previous regulatory concerns.

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

Charge 1a

1. Between 4 December 2017 and December 2019 whilst employed by Kings College Hospital NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    a. Failed medication competency assessments on the dates detailed in Schedule 1.

This charge is found proved in relation to 4 January 2018 and 28 March 2018.

In reaching this decision, the panel took into account the evidence before it.

The panel had sight of Ms Quinn's NMC witness statement dated 25 July 2024 where she stated that;

> *'The first issue raised was that Edith was unable to pass the drugs competency test. A drugs competency test is something that you do in the first few weeks/months. This was not as big a concern in isolation. It was recognised that Edith needed support in her induction, and* [Staff record of contact/facilitation with PDN document] *details what the plan would be to try and get her through her induction.'*
>
> *'…I attended a meeting on 11 April 2018 extending Edith's action plan for four weeks, due to the concerns of her not passing her drugs test. The drug test at the Trust was a very comprehensive drug test, so we split the test into two parts, which was my idea. Rather than her do it all in one, we allowed two sits, and she was given a lot of support leading up to the drug test, and she did pass it when we did it like that. We started to think that Edith learned in a different way, and we tried to adapt on the ward, which was hard to do on a surgical ward. From the offset, the Practice Educator had concerns about her learning, which is why they documented this. We had a really good practice development team at the Trust and there was a lot of support for Edith from this team. Her drugs test was an issue on induction but was an ongoing concern. She sat numerous drugs tests, but there were still issues after she had passed.'*

This was also confirmed in Ms Quinn's live evidence where she stated that;

> *'The reason I was asked to get involved is because the 3rd test was failed, which is very unusual"*

The panel also had regard to SAQ/01,'Communications log with Sarah Quinn' (dated 26 January 2023 and SAQ/03, 'Staff record of contact/facilitation with PDN document' dated 4 December 2017.

The panel noted multiple entries in this document pertaining to the test against the dates mentioned in the schedule 1 of the schedule of charges. The panel noted that there were only two out of 5 dates where there was an entry made pertaining to you failing the test.

On 4 January 2018 there was an entry made titled DAP test which stated that:

> *'Tolulope sat the Drug Test today but failed the calculations part and the clinical guidelines and policies part.'*

On 28 March 2018 there was another entry made titled DAP test which stated that:

> *'Tolulope took the drug test this morning as he has been on night shift and some weekends this has made it difficult to take the dap test which was originally schedule for the 27/02/18 I meet with Tolu this morning before the drug test and showed her, her past 2 dap test paper and went through the mistakes that she had made on these papers. Tolulope took the Dap test and has not been successful at this 3rd attempt. She was given feedback straight away. I also explained the concerns about her performance and capability and what the next step will be in term of another 4 weeks action plan. A copy of the performance capability Policy and Procedure was given to her to read and understand the process. Meeting to be arranged by ward manager, PDN and Tolulope on 3/04/18'*

The panel noted that on the 9 January 2018, you were given feedback about your drug test, and on the 30 April 2018 and 1 May 2018 you passed your test having taken it in two parts on two separate dates.

The panel considered your live evidence and reflection. The panel noted that you denied failing the medication competency assessment on the dates specified in the schedule of charges as you could not confirm the dates, however, you accepted that you had failed the medication competency assessment twice but passed on your third attempt.

Whilst the panel considered that Ms Quinn also stated that the this test was harder in this trust than at other trust, the panel taking all the factors into account, determined that on the balance of probabilities, this charge is found not proved in relation to 9 January 2018 where you had received feedback on another test failed, and not proved in relation to the 30 April 2018 and 1 May 2018, where you were given reasonable adjustments to allow you to take each part of the test on separate dates, and you passed those dates.

The panel however, did find this charge proved in relation to 4 January 2018 and the 28 March 2018.

Charge 1b

1. Between 4 December 2017 and December 2019 whilst employed by Kings College Hospital NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    b. Failed to successfully complete the capability action plans dated as per Schedule 2.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel had sight of Ms Quinn's NMC witness statement dated 25 July 2024 where she stated that;

'I exhibit Edith's development action plan, dated 25 January 2018, as [Neurosciences Professional Development Action Plan]. *This was a more in-depth plan to help Edith with her drugs tests. It was put in place not long after she started her induction. This wasn't a formal action plan, it was very informal. She had only been in post one month and, at this time, she had probably sat the test once or twice and failed, they realised there were issues, and then put this together to address them. The next assessment date was for February; they gave her a lot of time to re-study. The test at the Trust was quite a difficult test compared with other hospitals, so I could understand why she needed help to get through it. More formal management came later on when the communications logs were more detailed and we had developed further action plans.'*

This was also confirmed during Ms Quinn's live evidence during cross examination about the recording errors you made and then improved on, but did not sustain, she stated that;

"Improvement wasn't consistent - in nursing it has to be sustained improvement over a long period of time"

The panel had regard to the SAQ/04, 'Neurosciences Professional Development Action Plan' dated 25 January 2018 and the SAQ/07, 'Edith's development action plan' dated 3 April 2018. It noted that there was no evidence that the first 'informal' action plan was signed off, but it had evidence that all of the actions the January action plan were included in the April 2018 'formal' action plan.

The panel considered your written material you provided to it, and live evidence. It noted that you denied this charge on the basis that you passed this action plan and had not seen any documentation which states otherwise.

Although the panel had not seen the action plan for February 2018, it drew inferences from the two plans it did have sight of (January 2018 and April 2018) and it was of the view that the actions included in the January 2018 plan were also included in the April

2018 plan having not been signed off by the deadline of 26 February 2018, as stated in schedule 2 of the schedule of charges.

Therefore, on the balance of probabilities the panel found this charge proved.

Charge 1c

1. Between 4 December 2017 and December 2019 whilst employed by Kings College Hospital NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    c. On 5 March 2018, demonstrated poor infection control skills, in that you rinsed and then reused a tracheostomy catheter.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Quinn, dated 25 July 2024, stating that;

> *'…There was a concern that Edith had reused a tracheotomy catheter, after washing it out in the sink. This was an infection control concern as Edith could have introduced potentially harmful organisms into a patient's respiratory system. When you are trained in changing a tracheotomy this is something you are drilled not to do. The patients on the ward could also be particularly vulnerable. I did not know if Edith lacked understanding or had been lackadaisical…'*

> *'I exhibit a health care assistant statement, dated 5 March 2018, written by Monique Clarke ... This raises concerns with Edith washing a suction catheter out with tap water…'*

This was confirmed in Ms Quinn's live evidence where she stated that;

> *'There are no circumstances where that [rinsing and re-using] might be good practice'.*

The panel considered the SAQ/06 dated 5 March 2018, written by Ms Clarke where she records that an HCA had told her that;

> *'…She had seen the trained nurse used the suction cath X once but Edith washed it under the running tap water to clear the tube – she then put the catheter on the bed. The patient coughed again and the same catheter was used.'*

In your written material you had provided to the panel and your live evidence, you told the panel that you denied this charge, stating that:

> *'I followed the Trust standard of care procedure with tracheostomy care, and I did not rinse tracheostomy catheter instead I maintained a sterile field on how to clean the inner cannula tube by using a sterile pack that consists of (sterile water or saline water, gauze, cotton swabs, paper cups, brushes and pipe cleaners, a clean towel or chucks and non-sterile gloves).'*

The panel noted you also denied this during your meeting on the 8 March 2018 with the PDN at the time, who stated that they;

> *"… also put forward the complaint that she*[You] *was washing and reusing the single use disposable suction catheters from trache patients. She* [You] *denies ever doing that."*

The panel considered that you had been consistent in denying this, however, the panel noted its earlier decision on hearsay and placed more weight on the note written by Ms Clark as it was detailed and were of the view that this was contemporaneous evidence and had been raised locally with you, 3 days after the incident in question.

Therefore, on the balance of probabilities the panel finds this charge proved.

Charge 1d(i)

1. Between 4 December 2017 and December 2019 whilst employed by Kings College Hospital NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:
    d. On 2 March 2018:

        i. Made inaccurate recordings of observations of a patient with spinal deficit.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Quinn, dated 25 July 2024, stating that:

> *'Spinal observations go hand-in-hand with GCS scores, and you can do them separately or together… The spinal observations concern was that Edith had recorded and handed over spinal observations that hadn't been taken. I recall that this had happened, but I cannot recall how it had come to light or why Edith may have said observations were undertaken when they hadn't been. I recall this occurred towards the end of Edith's employment, at which point Edith had become increasingly upset at any meetings held, stating that she felt singled out*
> *Spinal observations are undertaken to see how damaged the nerves in the spinal cord are. To complete spinal observations you observe the strength and movement of patient's limbs. It is a very important observation as swelling on the spine and any damage could cause that person to be disabled for a very long time… Spinal observations are usually done pre and post operatively. If a spinal observation is*

not done when it is supposed to have been done, then it is quite neglectful. There is a risk the patient could become immobile or lose their bowel and bladder continence. I questioned if Edith was aware of the significance of such an observation. It is a very important assessment as reduced strength and movement in the limbs can indicate increased swelling in the spinal cord or further damage that can cause lifelong disability.'

The panel also considered the written material you provided to it, in relation to this charge, stating that:

'I deny this charge. I accept that inaccurate recordings may have been entered on an occasion, but I do not accept that this was due to a lack of knowledge, skill or judgement required as a band 5 nurse, but rather a record keeping error. I assessed the patient with the spinal chart used in assessing patients with spinal deficit and this goes hand in hand with GCS assessment tool as well. Spinal assessment is checking patient's hands and legs extremities to see how strong it is by assessing for normal power to no response on both upper and lower limbs.

Also checking their pupils and how well it reacts to light.

There's a possibility that I might have entered the wrong score on the patient's record but not to say I didn't have the knowledge of completing the assessment correctly would be wrong. I consider this a human error, not a lack of understanding.'

This was confirmed in your oral evidence where you denied this charge and stated that it may have been human error but you do not accept that you carried out this task inaccurately, and you stated that you would not guess or put a number in as you can read and are quite knowledgeable.

The panel was not provided with any documentary evidence in relation to spinal deficit observations.

Therefore, on the balance of probabilities the panel found this charge not proved.

Charge 1d(ii)

1. Between 4 December 2017 and December 2019 whilst employed by Kings College Hospital NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:
    d. On 2 March 2018:

        iii. Incorrectly completed Glasgow Coma Scale assessments/scores for a patient at the times as noted within Schedule 3.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Quinn, dated 25 July 2024, stating that:

> *'Edith had also calculated and recorded incorrect Glasgow Comma Scale scores and therefore the practice development team had worked with her… I think these records relate to incorrect GCS scores and spinal observations. Edith's GCS scores are highlighted. She had completed the GCS scores, but the patient had a tracheostomy and she had written a 5 under verbal response. If a patient had a tracheostomy this should be a T for tracheostomy, not a 5, as the patient couldn't*

speak. Most patients can't speak with a tracheostomy, although some can. She had therefore filled it in wrong. In the patient's records, Edith had written that the patient had no motor response in any of the limbs, but for the GCS, she had written a 6 under motor response. A 6 would indicate good motor response, but she had written that there was no power in the limbs, so it didn't tally up. It indicated that she was looking at the spinal observations separately, and didn't have an understanding of GCS, as what she had written didn't make sense.' (sic)

'…Eventually Edith needed to be put on a development plan which addressed different aspects of her practice, such as her ability to calculate GCS scores'

Ms Quinn also confirmed this in her live evidence stating there were concerns that you had been guessing or just putting in numbers as opposed to actually assessing the patient. She further stated that your ability to calculate scores got better and then worse.

You told the panel that you denied this charge. In your written material you provided the panel, you stated that:

'I deny this charge. I accept that inaccurate readings were entered on an occasion, but I do not accept that these were due to a lack of knowledge, skill or judgement as a band 5 nurse, but a record keeping error.

There's a possibility that I might have entered score on the patient's record but not to say I didn't have the knowledge of completing the assessment correctly would be wrong. I consider this a human error, not a lack of understanding. I am aware what the figures on the chart represent, e.g. "T" for tracheostomy and "6" for motor response indicating full limb power. I understand the rationale behind daily GCS and spinal observations and their importance in neurological care…

The Glasgow Coma Scale (GCS) is used to assess a patient's level of consciousness after a brain injury. By asking them various questions, you can

determine how alert they are. Based on their responses, the patient is given a score, with 3 being the lowest possible score and 15 being the highest.

The assessment looks at three areas: eye opening, motor response, and verbal response. Eye opening is scored out of 4, motor response out of 5, and verbal response out of 6. The highest possible score is 15.'

You further confirmed this during your live evidence where you told the panel that people will score things differently, and that human recording error does not mean a lack of understanding.

The panel also considered the document titled SAQ/07, 'Edith's entries in a patient's records' dated 2 March 2018. The panel noted the schedule times and scored you had inputted compared to other nurses. The panel further noted that your entries were higher than the entries recorded before and after by other nurses. On the 2 March 2018 you had reported that the patient had a GCS score of 15 at 11:01am and then a GCS score of 11 at 15:02pm and 19:14pm. Meanwhile, on the same day another nurse had the recorded the patients GCS score of 6 at 07:15am and 22:40pm. This was consistent with the GCS scores of the previous days and the next day.

The panel noted that the GCS score was an objective score that gives indication to the consciousness and ability of the patient. The panel determined that this is something a Band 5 nurse should be able to accurately assess and interpret and, it determined that this was a failure.

Therefore, on the balance of probabilities the panel finds this charge proved.

Charge 2a

2. "Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of

knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

a. On 19 January 2021, failed to change a VAC collection canister."

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Sartini dated 21 June 2024, which stated that:

'On 19 January 2021 Tolu did not change a VAC collection canister as she was too busy, leading to a surgically inserted VAC potentially needing to be changed, meaning another GA for the patient. The pump needed to be changed as the cannister was full. It's a negative patient therapy. It ensures constant suction on a wound. The pump had not been checked. It takes less than a minute to change a cannister and there was even one by the bedside. The patient could have ended up going back to theatre as a result, so it was rather serious. The patient wasn't left in pain, however, they could have got an infection and requiring another wash out of that area.'

This was also confirmed in Ms Sartini's live evidence where she stated that a VAC cannister would need to be changed when the machine beeps continuously and that it was the responsibility of the nurse looking after the patient to undertake this task or delegate appropriately.

The panel also considered the document AS/10 produced by Ms Sartini titled 'Email to Tolulope Akeredolu' dated 19 January 2021.

'Today after hand over there was a VAC pump in bed 29 that had a full canister meaning the wound had no suction on it through the night. You were aware of this

however I am unsure why the canister wasn't changed … it takes less than a minute to change the cannister and there was even one at the bedside.'

The panel further considered AS/12, the document titled 'First Formal Stage Capability Meeting Outcome' which stated:

'20th Jan 2021 – VAC collection cannister not changed overnight as she was too busy, leading to a surgically inserted VAC potentially needing to be changed, meaning another GA for the patient. This is a very quick task to complete

You told the panel you denied this charge and in your written material you provided the panel, you stated that:

'I deny this charge. This is on the basis that I handed over this incident. There was no VAC cannister next to the bedside there and then. As it was handed over this is not a failure on my part.

I acknowledge that the VAC was not changed due to the shift's intensity. I did inform the Nurse in Charge and intended to ensure that the incoming nurse took over the task. If there was a spare cannister present and I was unable to complete the change, I would have informed a colleague or handed it over appropriately.'

You confirmed this during your live evidence where you stated that you asked the nurse in charge about sourcing a replacement VAC collection canister, however, you did not deny that you did not change it as you were busy and had other duties such as IV's to do, and did not prioritise this. You confirmed in your live evidence that you were aware that the VAC collection canister needed changing approximately an hour before the end of your shift.

The panel determined that as a registered nurse, there was a duty on you to change or delegate appropriately, a VAC collection canister of a patient you were looking after. It

determined that there was a failure to do so as you recognised it needed to be done and spoke about the implications to the patient if it was not changed.

Therefore, on the balance of probabilities, the panel finds this charge proved.

Charge 2b(i)

2. Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    b. Demonstrated poor medications practice, in that you:

        i. On 14 April 2020, failed to follow the blood transfusion administration process and tractability.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Sartini dated 21 June 2024, which stated that:

> *'On 14 April 2020 a blood transfusion administration process and tractability wasn't followed. A unit of Red Blood Cells was issued on 14/04/2020 for this patient, but the transfusion tag was not returned, and there appears to be no evidence of transfusion in the Red Book. Datix submitted and I spoke with Tolu. I pulled the patients notes and found that the blood transfusion was administered by Tolu. This is a key part of the process as all blood components must by law have a full record of tractability from donor to patient receiving.'*

This was confirmed in the live evidence of Ms Sartini where she stated that she did not know when the blood arrived or when it was administered. She further stated that the Datix was raised from the blood bank themselves and that they did not know how long it was transfused over as there was no start and end time. She further stated that this may be classed as poor medication practice as it was out of line with the policy which is there to protect everyone.

The panel also considered AS/8, the Datix document titled 'Datix 262754', which had an entry stating that:

> *'A unit of Red Blood Cells was issued on 14/04/2020 for this patient, but the transfusion tag was not returned, and there appeared to be no evidence of transfusions in the Red Book … The Red Book has been examined for the transfusion evidence, a sticker was found in the Red Book which means that the blood unit was signed into the red book but they were not singed out in column C, D, or E which means there was no evidence of transfusion … I have pulled the patients notes and found that the blood had been administered by yourself, You had checked the blood into the red book however didn't sign the book to say it had been transfused. This is a key part of the process as All blood components must by law have a full record of tractability from donor to patient receiving.'*

The panel further considered that within the same Datix document there was an email response from you to Ms Sartini stating that:

> *'It was an INNOCENT mistake and thus would NOT repeat itself again'*

You told the panel that you denied this charge and in your written statement stated that:

> *'I deny this charge. This on the basis that this is not a failure to demonstrate the standards of knowledge, skill and judgement required with supervision as a Band 5 nurse, nor to demonstrating poor medical practice. Every Trust has their own way*

of carrying out a particular skills or tasks specific to each Trust. I can see from the NMC's evidence that this area was removed from the action plan and there were similar issues with other staff due to lack of training on this trust procedure. This was a single incident in my case.

This was my first time of carrying out this skill in this Trust, but I remembered doing this skill with a senior nurse in the ward. The issue around this was I think if I can remember validly, it was around not filling the form correcting or dropping the form in the right place for in the ward for the porter to correct it.

I had not previously transfused blood at the Trust. I was being supervised by the Nurse in Charge Janice, at the time. We completed the required documentation, but I mistakenly placed the blood tracking label in the wrong collection box, which was not intentional. I followed all procedural steps to the best of my knowledge.'

You further confirmed this in you live evidence where you stated that you did not accept that this was an example of poor medication's practice but was simply an administrative error and that it was an innocent mistake. You further stated that you did not accept that this amounted to a failure to demonstrate the standard of knowledge, skill and judgement required to practise as a Band 5 nurse.

The panel determined that you had been on the ward for 4 months at this point and as an experienced nurse, you should have known the importance of the safe administration of blood products as a 'therapeutic medicinal product' and the importance of traceability and so should have found out the trust procedure for yourself.

Therefore, on the balance of probability, the panel found this charge proved.

Charges 2b(ii)(1) and 2b(ii)(2)

2. “Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    b. Demonstrated poor medications practice, in that you:

        ii. On 19 April 2020, administered intravenous paracetamol to a patient in circumstances where:

            1. The patient was under the weight threshold to receive medication intravenously

            2. The patient’s prescription stated that they were to receive oral paracetamol

These charges are found proved.

The panel considered the two charges separately but have written them up together as they relate to the same patient and the same episode of medication practice.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Sartini dated 21 June 2024, which stated that:

> *‘On 19 April 2020 Tolu administered intravenous (‘IV’) paracetamol to a patient who was under the weight threshold. The patient’s prescription said PO (oral), as opposed to IV. Paracetamol was given IV due to expression of pain. The prescription chart was supposed to be tablet form. One of our clinical advisers emailed Tolu and informed her that it was not correct procedure and requested that she reflect on the incident. The patient was 49 kg and if they were 50 kg it would*

have been classed as a safe drug dose so no harm came to them and it wouldn't be particularly serious.'

This was confirmed in Ms Sartini's live evidence where she stated that the reason a patient needed to be of a certain weight to receive medication intravenously is because it is a drug processed by the liver, and a patients needs a reduced dose if they are below a certain weight to ensure appropriate clearance and avoid toxicity. She also stated that if a patient is refusing to take medication orally then a nurse would need to ensure the prescription is changed by a doctor and consider why the patient was not prescribed IV medication instead of oral. Ms Sartini also confirmed during her live evidence that you would have had access to another laptop, should the one you were using crash.

The panel also considered AS/1 the Datix document titled 'Datix 262098'.

Within this document it showed an entry and email from a Rebecca Tomlin (Ms Tomlin) to you stating that:

'Paracetamol was given IV due to expression of pain and Patient was hot. On the prescription chart was suppose to be tablet form … NIC, Pharmacy and Doctor was informed'(sic)

'You explained that the paracetamol was prescribed as PO/IV, but preset to tablet so you were unable to change the drop down option for route …You both went to sign for it, and realised that his weight was 49kg … It sounds like you made a compassionate decision … missed checking his weight'

The panel further considered within the same document, which stated that:

'19th April 2020 – Datix 262098 – iv paracetamol administered Oral written up.'

You told the panel you denied this charge, and in your written material you provided the panel, you stated that:

> *'I deny on the basis that this is not failure to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse. It is not demonstrating poor medications practice as I had to act in the best interests of the patient at the time, who had a sky-high temperature.*
>
> *At the time, I knew the patient's weight was under threshold thus, that was why we worked out much he would receive by giving it IV way upon administration. This patient lacks capacity for a start and previous nurses that had cared for this patient previously stated in their handover that he was a bit handful almost to the extent that he was also being special and had to wear mittens simply because he was non-compliance to care and treatment.*
>
> *I acknowledge the prescription stated oral Paracetamol, however, the patient in question was non-compliant with oral medication and presented with communication difficulties. I accept it was written to give oral Paracetamol to patient, but the patient was spiking and the clinical observation carried out several times. I remembered this shift was a weekend shift, busy with shortage of staffing issues too… Together we made a decision to administer the Paracetamol intravenously considering the patient's weight of 49 kg and calculated an appropriate dose accordingly. Then we both mutually decided to give IV paracetamol at the exact dose he would have had if it was orally. After calculating the dosage, we proceeded together to the patient's bedside, confirmed the patient's identity and administered the IV Paracetamol.'*

You further confirmed this in your live evidence where you stated that the patient declined paracetamol in tablet form and so administering intravenously (with the nurse in charge) was in the patient's best interests.

The panel determined that it was not best practice for you to overwrite the medication and that if the patient was not taking medication orally you should have spoken to a doctor to have the prescription changed if deemed appropriate.

Therefore, on the balance of probabilities the panel found both limbs of the charge proved.

Charge 2b(iii)

2. Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    b. Demonstrated poor medications practice, in that you:

        iii. On 7 May 2020. Countersigned for a dose Oxycodone that was 10 times the prescription dose.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Sartini dated 21 June 2024, which stated that:

'On 7 May 2020, when acting as a second-checker, Tolu co-signed for 10mg of Oxycodone to be administered to a patient when they were only prescribed 1mg. The patient experienced opioid toxicity as a result of this error. Whilst checking the CD's overnight it was noticed that 10mg of Oxycodone was signed for in the book. The prescription was checked and it should have been 1mg and not 10mg. The patient was handed over and remained drowsy for a period. They received 10 times the dose they should have so this would be particularly serious. The patient was easily rousable, however, required some oxygen.'

This was confirmed by Ms Sartini in her live evidence where she stated that the second checker is allocated when giving controlled drugs, and that both nurses are equally accountable and have to make sure checks are done independently. She further stated that the second checker is the one that checks the dose, route and whole prescription.

The panel also considered AS/15, the document titled 'Information regarding Datix' dated 7 May 2020 which is an email from Kelsie Gurney (Ms Gurney) to you stating that:

> *'You checked this medication out with your colleague who was caring for the patient, and co-signed on the prescription that 1mg was administered SC. However in the CD book, it is documented and signed by both you and your colleague that you removed 10mg/1mL of Oxycodone Inj, and nowhere is it noted that any was discarded or not used. Based on this, we discussed that it appears that the full 10mg was administered to the patient – 10x the dose that was prescribed. I informed you that clinically it did appear that the patient was experiencing opioid toxicity in the hours following the administration of oxycodone, as he was very drowsy, his oxygen requirements increased, and he also went into urinary retention requiring catheterization … you have agreed that it is your signature in the CD book'*

You told the panel that you denied this charge and in your written material you provided the panel, you stated that:

> *'I deny on the basis that this is not failure to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse. I accept that I signed for the wrong dose, of 10mg instead of 1mg, but deny this is demonstrating poor medications practice as this was not a medication error. This was a recording error in the book that I wrote in at the time. I adhered to all the protocols in place at the time of the medication administration… I didn't notice the error immediately because she had already worked out the math before calling me over, and I trusted her. I also saw that she had drawn the correct amount of medication for the patient, checked the expiration date, and completed all the*

necessary checks…This was a genuine mistake, and I have learned from it. Moving forward, I will always verify the remaining medication myself before signing, and I will never co-sign a medication unless all the details are fully filled out.'

You further confirmed this in your live evidence where you told the panel that you admitted the facts of the charge but did not accept that this was an example of poor medications practice but simply a recording error. You stated that the patient was administered the correct dose and you therefore do not accept that the patient suffered an overdose.

The panel, taking into account all the above, determined that you had countersigned for a dose that was recorded to have been administered for 10x what it was supposed to be, however, the panel noted that the NMC was not charging you with causing an overdose, but was of the view that you should have ensured it was the correct dosage as you were equally responsible and that checking what you are countersigning is a part of the knowledge and standards required by a Band 5 nurse, in order to safely administer a controlled drug.

Therefore, on the balance of probability, the panel found this charge proved.

Charge 2b(iv)(1)

2. Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    b. Demonstrated poor medications practice, in that you:

        iv. On 1-2 June 2020, during a night shift:

            1. Administered intravenous Vancomycin at an incorrect rate.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Sartini dated 21 June 2024, which stated that:

> *'During the night shift of 1-2 June 2020 Tolu administered IV Vancomycin at the incorrect rate.'*

This was confirmed in Ms Sartini's live evidence where she stated that you had set the infusion to administer over 2 hours, instead of 3 hours. She further stated that on the medication prescription there is a guideline called MEDUSA, which gives guidance on how to administer any IV medication.

The panel also considered AS/4, the Datix document titled 'Datix 265065' which shows an entry from you stating that:

> *'I was with the patient and SN1 noted that SN2 had just put up the Vancomycin as she mentioned it in handover, but noted it was only running for 2 hours so changed the rate to 3 hour. Increased rate to 3 hours as per medusa and informed PDNs.'*

In your handwritten refection dated 16 June 2020, the panel noted a detailed contemporaneous reflection from you which stated that the Vancomycin was set by you, over an incorrect time period.

> *'...I then went to give the medication to patient however I made a mistake in the rate I set the medication. Which meant the medication was given faster than the recommended'(sic)*

The panel further considered AS/12, the document titled 'First Formal Stage Capability Meeting Outcome' which had an entry stating that:

'2nd June 2020 – Datix 265065 – vancomycin over incorrect time'

You told the panel you denied this charge and stated within written material you provided the panel, you stated that:

> *'I deny this charge. I definitely did not administer IV Vancomycin at the incorrect rate, despite what is written in my reflection statement at the time. I was under pressure to complete the reflection and was not thinking straight when I completed the reflection.*
>
> *I consulted the Trust's online resource 'Medusa' to confirm the correct infusion duration. The preparation was double-checked by another nurse, and we jointly administered it after confirming the patient's identity.*
>
> *I am experienced with administering Vancomycin and always refer to Trust protocols. I followed the Trust policy and guidelines on how to give intravenous Vancomycin, and I did not set the wrong rate because I used the Trust's intranet Medusa to see how to prepare the antibiotic infusion anytime, I am administering or giving medication intravenously because of the seriousness of the medication.'*

You further confirmed this during your live evidence and denied that you administered the incorrect rate.

The panel considered that you had told it, that you had written that detailed reflection under stress, however, it was not persuaded by this explanation as you had previously stated under oath that you would not sign anything which had not happened.

Therefore, on the balance of probability, the panel found this charge proved.

Charge 2b(iv)(2)

2. Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

b. Demonstrated poor medications practice, in that you:

iv. On 1-2 June 2020, during a night shift:

2. Recorded an incorrect concentration of Fentanyl on a patient's patient-controlled analgesia syringe.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Sartini dated 21 June 2024, which stated that:

'During the night shift of 1-2 June 2020 Tolu documented an incorrect concentration of Fentanyl on a patient's PCA (patient-controlled analgesia) syringe.'

This was confirmed in Ms Sartini's live evidence where she stated that the details for the drug can be found on the hand written sticker and that both the nurses signing for the medication are responsible as there is a main signatory and a co-signer.

The panel also considered AS/4, the Datix document titled 'Datix 265065' which shows a detailed reflection from you on 16 June 2020 stating that:

'I had to set up fentanyl PCA infusion to a Patient I nursed from a Post-op surgery on a night shift duty. I explained to the Patient what my intention where to gain understanding from him and consent. I explained the situation of things to Nurse-In-Charge and so that she can be my second checker for the controlled drug.

We both checked out the controlled Drug to be administered to the Patient out of the controlled drug book against the (pg 59) prescription chart.
The nurse-in-charge prepared everything I needed to mix the Drug in a tray for me and thanked her. Furthermore she then watched me mixed the drug in a syringe with four ampoules of saline solution and I primed the IV infusion line. On a piece of IV infusion paper, I wrote down the Drug name and the strength in a ML that it comes in, what I am mixing with and the amount I am using to mix the Drug. My second checker, "Nurse-In-Charge" checked what I had written down in the IV infusion paper and approved and signed the paper with me.'(sic)

'The mistake I made was I incorrectly wrote the total volume of the drug as 40mls instead of 50mls which would indicate a stronger dose of the drug running'

'I would make sure that next time I double check my sticker label thoroughly to ensure that my numbers of strength, MLS and total concertation is crystal clear'

The panel further considered AS/12, the document titled 'First Formal Stage Capability Meeting Outcome' which had an entry stating that:

'2nd June 2020 – Datix 265040 – PCA label 40ml not 50 ml recorded unknown if it was an incorrect amount in syringe or error writing the label'

You told the panel that you denied this charge and in your written material you provided the panel, you stated that:

'I definitely did not record an incorrect concentration of Fentanyl on a patient-controlled syringe despite what is written in my reflection statement at the time. I was under pressure to complete the reflection and was not thinking straight when I completed the reflection.

The allegation is not true at all because the whole process was done alongside with the Nurse-In Charge of the night shift with me. I was the one that was mixing the controlled medication and the nurse in charge filled out the IV medication paper and we both cross checked, performed the bedside checks with the patient and connected the device to the device that is locked, and the patient gets the drug every five minutes that can be controlled by the patient too by pressing the button to get a dose.

I was not the one who wrote on the IV label ("SIP"). In our practice, the second checker write the label while the administering nurse prepares the syringe. The Nurse-In-Charge on the day was Jennifer Dumalos, who co-signed and wrote the label while I prepared the medication. We jointly affixed the label and administered the PCA after final checks.'

You confirmed this in your live evidence where you denied this charge but accepted being the second checker for this medication and administered it. However, you denied writing in the label which was the role of the nurse accompanying you. You also stated that you may have misworded the account in your response at the time, saying it was you yourself instead of the nurse in charge and explained that English was not your first language.

Whilst it is noted that English is not you first language, the panel did consider that you undertook your secondary education and higher education in the United Kingdom (the UK) in English. Furthermore, you had been a nurse for many years and were able to articulate clearly when giving your evidence.

The panel considered that you had told it, that you had written that detailed reflection under stress, however, it was not persuaded by this explanation as you had previously stated under oath that you would not sign anything which had not happened.

Therefore, on the balance of probability, the panel found this charge proved.

Charge 2b(v)

2. Between 2 December 2019 and May 2023 whilst employed by Guys and St Thomas NHS Foundation Trust, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

    b. Demonstrated poor medications practice, in that you:

        v. On 15 June 2020, caused a delay in insulin administration for a patient who had elated blood sugar.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it.

The panel considered the NMC witness statement of Ms Sartini dated 21 June 2024, which stated that:

> *'On 15 June 2020 there was a delay in insulin administration where the patient had an elevated blood sugar of 15.5. The patient was supposed to have insulin PRN if BMs are elevated over 11.1. Tolu hadn't actioned this or provided any treatment for the patient, but instead went on her break.'*

This was confirmed in Ms Sartini's live evidence where she stated that if the patients' blood sugars level is over 15 then it would be general practice to treat it. She further stated that there is no defined time a practitioner should take action, but as soon as they realised this, then it should be actioned straightaway and if not then you should ask a colleague to action it.

The panel also considered AS/7, the document titled 'Email to Tolulope Akeredolu' dated 15 June 2020 From Ms Sartini to you stating that:

‘It was raised to me by a member of the team that you had been informed that the patient had an elevated blood sugar of 15.5, the patient is supposed to have insulin PRN if BMs are elevated over 11.1 (2 units.)

You hadn’t actioned this or provided any treatment for the patient but instead went on your break.

When I questioned you on the matter after returning from your break you said you were aware of this but was already on your way to your break.

I do worry that should your patient have had a low BM you would have reacted just the same? There are serious consequences if both high and low blood sugars.’

The panel further considered AS/12, the document titled ‘First Formal Stage Capability Meeting Outcome’ which had an entry stating that:

‘15th June – Concerns raised verbally, delay in insulin administration – discussion with AS’

You told the panel that you denied this charge and in your written material you provided the panel, you stated that:

‘I did not do this. I would have handed over this if I was going on a break. There was one incident I can recall where there was a delay in giving insulin due to prescription issues, but this was not caused by me. I had called the team and thus I was awaiting a response back. I was waiting for the Diabetes team to prescribe the insulin type and dose range to be given according to the CBG reading.’

This was confirmed in your live evidence where you deny causing delay, stating you wouldn’t go on your break if this was the case and would raise it with someone. You stated that what Ms Sartini stated was false and did not know why she would make this up.

The panel took into account the contemporaneous evidence and noted that although you denied the charge there was contemporaneous evidence, AS/7, from Ms Sartini that she had discussed this with you immediately on your return from your break, but you did not state this in your oral evidence.

Therefore, in all the circumstances, on the balance of probability, the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Submissions on lack of competence

The NMC has defined a lack of competence as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

Ms Morgan invited the panel to take the view that the facts found proved amount to a lack of competence.

Ms Morgan identified the specific, relevant standards where your actions amounted to a lack of competence. Ms Morgan submitted that lack of competency needs to be assessed using a three stage process:

- Is there evidence that you were made aware of the issues around your competence?
- Is there evidence that you were given the opportunity to improve?
- Is there evidence of further assessment?

Ms Morgan submitted that the facts found proved show that your competence at the time was below the standard expected of a Band 5 registered nurse. She reminded the panel that the number of charges found proved as well as the volume and variety of charges demonstrated a lack of competence.

Ms Chapman submitted that you do not accept that the charges found proved amount to a lack of competence. She submitted that the mistakes you made were mistakes another Band 5 nurse could have made and are not indicative of an overarching failure to perform to the required standards. Ms Chapman submitted that for four years prior to these events, you were practicing at the required standards. You practised at the Royal Marsden Hospital (the Trust 3) under an interim conditions of practice order and Ms Chapman told the panel that this was 'largely positive'.

Ms Chapman submitted that in relation to the charges found proved, regarding your time at Trust 1, it is said to not be an easy place to work with lots of new skills to be learned. She submitted that there were others that found the medications test difficult and therefore your case is not an isolated one.

[PRIVATE]

Ms Chapman submitted that in relation to the charges found proved, regarding your time at Trust 2, that things were going well for you at Trust 2 until you heard about the NMC referral. She submitted [PRIVATE] in your opinion other people's attitude towards you had changed because of this, which led to further issues.

Ms Chapman submitted that when it comes to the specific charges, especially the charges relating to the administration of IV paracetamol, that it was a weekend where there was no doctor available and this was a time sensitive situation with a vulnerable patient who was in pain. She further submitted that the patient was only one kilogram(kg) below the threshold and there was no harm caused. Ms Chapman submitted that there is evidence from another nurse that you and your colleague were acting in the best interest of the patient.

Ms Chapman further submitted that this is similar to the charge about blood traceability, as it is evidenced that this was not an isolated issue but a systemic issue that the ward you were working within had at the time. Ms Chapman submitted that given the context to the charges found proved, there is evidence of good practice before and after these events , and the charges found proved are not representative of a fair sample of your work over a sustained period of time and therefore do not amount to a lack of competence.

Submissions on impairment

Ms Morgan 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 referred to the NMC guidance DMA-1.

Ms Morgan took the panel through their powers available to it for making a decision on your impairment. She submitted that impairment is a test to look into your fitness to practice now as opposed to when the charges found proved first arose. She submitted that the NMC do not believe that you can practice safely without restriction.

Ms Morgan stated that during the course of the hearing you say you are taking steps to improve and address your practise. However, she submitted that this was not sufficient to find that your conduct would be unlikely to be repeated. Ms Morgan submitted that in relation to public safety, the panel is invited to consider the seriousness of the conduct in question, how you have responded to these instances and the likelihood of repetition of this behaviour. Ms Morgan also submitted that the panel should consider your personal circumstances at the time.

Ms Morgan submitted that in relation to public confidence in the profession and the professional standards, the panel could make a finding of impairment on this ground, even if there is no ongoing risk to the safety of the public. She submitted that this would be appropriate where the facts are so serious that a finding of impairment is necessary to maintain and uphold public confidence in the profession, and the panel could consider whether it believed you had done enough to fully address the issues at hand.

Therefore, Ms Morgan invited the panel to make a finding of impairment.

Ms Chapman submitted that you did not accept that your fitness to practice was currently impaired. She submitted that the panel would be able to see the passion with which you talk about nursing and caring for patients. Ms Chapman submitted that you have

demonstrated knowledge in your evidence and that matters have progressed since the time of these charges, some of which took place 8 years ago.

Ms Chapman submitted that you have been prevented from nursing for the past two and a half years due to your interim suspension order, and therefore this should not be held against you. She submitted to the panel to that there was a good reason as to why you have not been able to obtain a healthcare related role in this time, [PRIVATE].

Ms Chapman submitted that you have made efforts to keep on top of developments in nursing and maintain your practise. She referred the panel to the numerous certificates you provided, some of which are fairly recent from last year and this year. Ms Chapman submitted that you still speak to your nursing colleagues and read the nursing times. She further submitted that prior to the imposition of an interim suspension order, you were working at Trust 3, in a nursing role where you were supported in accordance with your interim conditions of practice order.

Ms Chapman submitted that you had support at the Trust 3 from the PDN and within exhibits RT1 and RT15 there is evidence of your good progress, which all demonstrate remediation. She submitted that you have provided a detailed statement and reflection on the matters and are still doing work to remediate any perceived concerns with your practice.

Ms Chapman referred the panel to the numerous testimonials from your friends and colleagues and submitted that from these testimonials it is evidence that you can practice kindly, safely and professionally, and are capable of remaining on the register without restriction.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Holton v GMC* [2006] EWHC 2960, *Calhaem v GMC* [2007] EWHC 2606 Admin and *Krippendorf v GMC* [2001] WLR 1054.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

*'**8 Work co-operatively***
To achieve this, you must:

8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

10.2 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
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

To achieve this, you must:

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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'

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the average band 5 registered nurse and not by any higher or more demanding standard.

The panel considered that the charges span over various areas of nursing practice and occurred at two different trusts, over a period of time. The panel considered that it was a high pressure role that you were in and that you were struggling to cope, noting your comments on the ward being busy and short staffed. [PRIVATE]. The panel considered that you had been struggling with the medications assessment and passing your action plan which had been in place with significant support from the PDN's for several months, before you passed. [PRIVATE].

However, the panel also noted that although it was a high pressure environment, you were given a reduced caseload with additional support and offered the choice to be moved to a different ward with less pressure in order to have a 'fresh start', while still receiving the support. However you refused this offer telling the panel you were worried about what

colleagues might think. The panel noted that your improvements after you passed the medications tests and action plan were inconsistent and you continued to make significant patient safety errors.

The panel when considering the issue of competence or lack of it, noted that you are to be assessed by the standards reasonably to be expected of a nurse of your qualifications and experience.

In all the circumstances of this case, including the number of areas of concern and the length of time over which the concerns occurred, the panel determined that your performance demonstrated a lack of competence. The concerns in this case amount to a fair sample of your work across two trusts and occurred over a period of three years, between December 2017 and January 2021.

Decision and reasons on impairment

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

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

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> 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) *….'*

The panel found that limbs a - c of the *Grant* test are engaged as to the past. The panel found that your lack of competence put patients at a potential risk of harm. Your lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel then went on to consider the three limbs of *Grant* with its focus on the future.

The panel were of the view that your lack of competence is clinical in nature, and therefore, it was possible for the concerns be to address through retraining and were capable of remediation.

When considering insight, the panel considered your reflections in both your written and live evidence. It noted that you had a passion for nursing and care for your patients, however, the panel were of the view that you had not shown sufficient insight into how your actions affected your colleagues, patients, the profession and the NMC as a regulator.

In its consideration of whether you had taken steps to strengthen your practice, the panel took into account the numerous training certificates which demonstrated a willingness to learn, however, it noted that you were not able to work as a nurse since you had been suspended [PRIVATE].

The panel then went on to consider whether there was a risk of repetition, it noted that you had worked for Trust 3, and had worked there without any incident, however, the panel had sight of the NMC witness statement of Rowena Trono (Ms Trono) dated 2 July 2024, where she stated the following:

> *'Tolulope spoke about previous experiences and how she felt persecuted by allegations made by previous employers. She felt angry that when involved in drug errors she felt like she was the only nurse to be held to account by being placed on a supervision order. They discussed the role of reflective practice in helping us as practitioners to recognise our role in incidents, accept responsibility for our actions*

and reflect on steps that could be taken to develop practice. It was highlighted that the NMC reflective templates could be used to demonstrate this. They discussed how stressed and persecuted Tolulope feels about what has happened. It was explained that I understood how she feels this way but in order to move forward and demonstrate that she can practise autonomously Tolulope needs to demonstrate that she acknowledges areas that she needs to develop her practice and show what steps she has taken to facilitate this.'

The panel was of the view that there is a risk of repetition based on the fact that you have not been able to demonstrate a strengthening of your practice. You have not demonstrated or accepted that there are a number of areas of clinical practice where you need to take responsibility in order to understand the consequences of your actions. This will enable you to develop and strengthen your practise to prevent errors involving patient safety from occurring again. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that, in this case, a finding of impairment on public interest grounds was required. The panel concluded that a member of the public, would be seriously concerned if a finding of current impairment on public interest grounds were not made, given the nature of this case.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Ms Morgan referred the panel to the NMC guidance on sanction, SAN-2 and referred the panel to the case *of Kamberova v Nursing and Midwifery Council* [2016] EWHC 2955 (Admin).

Ms Morgan submitted to the panel the following aggravating factors of your case:

1. Prolonged and sustained nature of the incidents, which took place over a number of years and within multiple trusts.
2. The risk that was posed to patients by virtue of the errors you made, despite no actual harm being reported.

Ms Morgan informed the panel of the sanctions available to them, stating that no action and a caution order would not be appropriate or address the public protection and public interest in this case.

Ms Morgan submitted that a conditions of practice order would also not be appropriate in this case. She submitted that there is no evidence of deep seated attitudinal concerns and that the facts found proved are clinical in nature and therefore there are identifiable areas of the professional practice that could be addressed through retraining. However, the spectrum and variety of the errors seem to indicate a pattern which shows what you

struggle with. It is therefore difficult to say whether or not there is a realistic possibility of you resolving these through retraining considering the level of supervision and assistance you had been given before at a local level. Ms Morgan further informed the panel that you had been subject to an interim conditions of practice order during your time at Trust 2, where you were being supported and supervised, but this was not sufficient to protect the public as additional concerns were raised at Trusts 2 and 3 whilst you were subject to the interim conditions of practice order.

Ms Morgan submitted that the NMC has concerns over your insight into [PRIVATE], noting there were concerns over your general attitude towards it and how you responded to questions surrounding it.

Ms Morgan submitted that in light of the panel's earlier decision on impairment. She submitted that your impairment and lack of insight was very serious but not fundamentally incompatible with you continuing to be a registered nurse. Ms Morgan submitted that it was not unrealistic to say that you could return to practice in the future, however, it may not be right now at this stage. Ms Morgan submitted that there is a risk to the safety of the public if you were to be allowed to practice from today and that the NMC have concerns as to whether a conditions of practice order would be successful at this stage.

Ms Morgan, therefore submitted that a suspension order would be the most appropriate and proportionate order, giving you time to address your insight, protect the public and satisfy the public interest in this case.

Ms Chapman submitted that the appropriate sanction in your case would be a conditions of practice order. She further submitted that you have reflected on the panel's findings and accept that no action or a caution order would be unrealistic in light of these findings. Ms Chapman submitted that where the panel have identified a risk to the public, you would be willing and able to comply with conditions and work with them in order to strengthen your practice and address the concerns identified.

Ms Chapman submitted that the panel noted in its earlier decision on impairment that the concerns are all clinical matters which are remediable and could be addressed through retraining. She further submitted that the concerns are not evidence of any deep seated attitudinal issues and therefore, conditions could be formulated that would be appropriate workable, measurable and proportionate to protect the public and allow you to return to safe practise.

[PRIVATE]

Ms Chapman went on to suggest to the panel the following conditions which could be formulated to address both the public interest and public protection concerns.

1. One sole substantive employer or if it is an agency then for a long term placement to which the panel could put a limit as to the period of time.
2. An element of supervision, which would define areas that relate to the charges found proved until you are signed of as competent in those areas of concern
3. Monthly meetings to discuss the areas of concerns
4. Relevant training, courses of study and disclosing conditions when applying for any new jobs.

Ms Chapman submitted that a conditions of practice order with a review would be the most appropriate order and would further protect against harm caused to the public while addressing the public interest. This way you progress could be measured and considered by future panels. She further submitted that the panel could provide you with a route map of what you need to do in order for that next review and to consider removing or amending conditions.

Ms Chapman submitted that a suspension order would be disproportionate in this case, given that you are currently on an interim suspension order, this has derailed your career [PRIVATE]. She referred the panel to the case of *Akhtar v General Dental Council (GDC)*

[2017] EWHC 1986 (Admin), which gives some guidance around where time spent on an interim suspension order could affect a substantive sanction.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the aggravating features of your case. The panel noted the following:

- Prolonged and sustained issues in areas of basic nursing practice over multiple years, between two trusts, even though no harm was caused, significant errors were made.
- Lack of insight into your failings and the impact on patient safety, for example, you refused to move to another less stressful ward when this was offered, as you were afraid of how you would be perceived by others without any consideration to patient safety.
- Contradictions between your contemporaneous written reflections, in which you acknowledged many of your failings and your evidence and material provided to the panel during the hearing which denied many of the matters admitted earlier.

The panel also took into account the mitigating features of your case. The panel noted that your personal issues did play a part at the time and it also noted that you had a willingness to learn, by undertaking online training courses. However, the panel noted that this was a

limited willingness to learn as you have not reflected on how you would embed this learning into your practise and do things differently in the future.

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

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

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

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practise would not protect the public. The panel determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*

- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *…*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel considered that there was no evidence of any deep seated attitudinal issues. However, it noted that you had been on an interim conditions of practice order during your time at Trust 2 and Trust 3, and although you had made some progress, you were still making errors which could have put patients at a risk of harm. The panel considered that you may have viewed that being on an interim conditions of practice order as punitive, instead of regarding it as a way to help you work towards full competency as a nurse as described by Ms Trono at Trust 3.

The panel further considered Ms Chapman's submissions that a conditions of practice order would help you get to a place where you would be able to practice safely, however the panel was not satisfied that this was the case at this point in time. The panel has determined that you have not shown sufficient insight into all the concerns in this case. Now that facts have been found proved, the panel hope that you will be able to use the opportunity to move forward and reflect on your failings and the impact they had on patients, colleagues, the wider profession and the NMC as its regulator.

The panel determined that the lack of competence identified in this case was something that could be addressed through retraining. However, given your limited insight, absence of deep reflection, lack of understanding of the impact your conduct has had on patient

safety, the panel was of the view that it could not formulate relevant, proportionate, workable or measurable conditions that would be appropriate at this time.

Furthermore, the panel concluded that the placing of conditions on your registration at this time would not adequately address the seriousness of this case, nor protect the public, nor satisfactorily address the public interest.

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

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *...'*

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

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

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

The panel was satisfied that the lack of competence in your case was not fundamentally incompatible with you remaining on the register. The panel was of the view that the nature of these charges relate to the fundamental basic principles of the nursing profession, primarily, documentation and record keeping, medication administration and infection control. It was also of the view that while it would be possible for you be fit to practice in the future, a period of suspension, where the facts have been found proven, would allow you to take time to deeply reflect and accept what has happened, in order for you to be able to demonstrate developed insight and remorse into your failings as a nurse and impact it had on patient safety. Furthermore, a period of suspension would allow you to work towards not only undertaking relevant training and also reflect and articulate how you would apply the knowledge acquired into practice.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public protection and public interest issues in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of six months was appropriate in this case.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Up to date reflection that demonstrates your insight into your failings and why the public should be satisfied that the same mistakes would not happen again.
- Acknowledgement and reflection on what you have learned from this case and the impact your failings had on patient safety, patients, your colleagues, the wider profession and the NMC as its regulator.
- Evidence of paid or unpaid work related to healthcare.
- Evidence of your reflection and learning and how you would apply the knowledge gained from the training you have undertaken, with a particular emphasis on documentation and record keeping, medication administration and infection control.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

Ms Morgan submitted that the panel should impose an 18 months interim suspension order today to cover any appeal period.

Ms Chapman submitted that she had no objections to an interims suspension order.

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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to cover any potential appeal period.

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

That concludes this determination.