Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

**16 October –20 October 2023, 15 December 2023,
29 January – 2 February 2024, and 12 - 14 February 2024**

Virtual and Physical Hearing

Name of Registrant:	Ethel Delali Adjo
NMC PIN	95Y0074O
Part(s) of the register:	Sub part 1 RN1: Adult nurse, level 1 (25 May 1995)
Relevant Location:	Swindon
Type of case:	Misconduct
Panel members:	Mark Gower (Chair, Lay member) Janet Fitzpatrick (Registrant member) Anthony Griffin (Lay member)
Legal Assessor:	Oliver Wise (16 October - 20 October 2023, 29 January - 1 February 2024, 12 - 14 February 2024) Ashraf Khan (2 February 2024)
Hearings Coordinator:	Monsur Ali
Nursing and Midwifery Council:	Represented by Tope Adeyemi, (16 October –20 October 2023) Anna Leathem (15 December 2023) and Robert Rye (29 January - 2 February 2024,12 - 14 February 2024), Case Presenters
Miss Adjo:	Not present and not represented at the hearing (16 October - 20 October 2023), present but not represented (15 December 2023, 29 January - 2 February 2024, and 12 - 14 February 2024)
Facts proved:	Charges 1, 3a, 4b, 4c, 4d, 6, 8c, 8d, 9a, 9b, 9c, 10a, 10b, 10c, 10d, 10e, 11a, 11b, 11c, 12a, 14a, 14b, 16a, 16b, 16c, 17, 18, 21a, 21b, 22, 23, 24, 25a, 25b, 26, 27b and 27d

Facts not proved:	Charges 2a, 2b, 2c, 3bi, 3bii, 4a, 5, 7, 8a, 8b, 10f, 12b, 12ci, 12cii, 12ciii, 13, 15a, 15b, 19a, 19b, 20, 21c, 27a and 27c
Fitness to practise:	Impaired
Sanction:	Suspension order (5 months)
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Adjo was not in attendance and that the Notice of Hearing letter had been sent to Miss Adjo's registered email address on 5 October 2023. The panel had regard to the email evidence confirming this.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates, and venue of the hearing and, amongst other things, information about Miss Adjo's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Adjo

The panel next considered whether it should proceed in the absence of Miss Adjo. It had regard to Rule 21 and heard the submissions of Ms Adeyemi who invited the panel to continue in the absence of Miss Adjo.

Ms Adeyemi submitted that Miss Adjo has voluntarily absented herself. She referred the panel to Miss Adjo's letter to the NMC dated 27 June 2023 which states:

> *'Furthermore, not having the resources to fight the false allegations made against me, it is not therefore worth it coming for a hearing without representation. In view of this I will NOT be attending the hearing.'*

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel decided to proceed in the absence of Miss Adjo. In reaching this decision, the panel considered the submissions of Ms Adeyemi and the advice of the legal assessor. It had particular regard to the overall interests of justice and fairness to all parties. The main considerations were:

- An application for adjournment had not been made by Miss Adjo;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Miss Adjo has written to the NMC stating that she will not be attending the hearing;
- 12 witnesses are due to give oral evidence during this hearing;
- Not proceeding may inconvenience the witnesses, their employers and the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses to recall events accurately; and
- There is a strong public interest in the expeditious disposal of the case, particularly as the charges relate to the period November 2018 to May 2019.

There is some disadvantage to Miss Adjo in proceeding in her absence. The panel noted that the evidence upon which the NMC relies has been sent to her at her registered email address and the charges are not admitted. Furthermore, Miss Adjo will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. The limited disadvantage is the consequence of Miss

Adjo's decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair and appropriate to proceed in the absence of Miss Adjo. The panel will draw no adverse inference from Miss Adjo's absence.

Details of charges

That you, a registered nurse, whilst working at Great Western Hospitals NHS Foundation Trust:

1. On 7 November 2018, having given that date as your start date, told LN, your line manager, that you could not stay that day, and left;

2. On 14 November 2018;
    a. Failed to obtain the consent of an unknown patient before carrying out care;
    b. Failed to wash your hands and/or put on gloves before checking a pressure ulcer;
    c. Failed to clean equipment after using it;

3. On 15 November 2018;
    a. Failed to appropriately assess an unknown patient during triage by failing to ask necessary questions;
    b. Failed to make an appropriate record of the conversation, in that you;
        i. Failed to use appropriate language, referring to the patient's husband as "hubby;"
        ii. Failed to note the advice you gave during triage;

4. On 19 November 2018;
    a. Told AM, your clinical supervisor at the time that that you were competent in catheterisation, tissue viability, insulin and IV administration;

b. Failed to provide these competencies to AM at any point following that conversation;
c. Told LC2, a colleague, that you believed only doctors could change suprapubic catheters;
d. Acted unprofessionally, in that you tried to persuade LC2 to let you change the catheter when you were not signed off in front of the patient;

5. Your conduct at charge 4.a. was dishonest, in that you knew you did not have the necessary competencies relating to catheterisation and/or IV administration;

6. On 21 November 2018, confirmed to AM that you had IV administration competencies;

7. Your conduct at charge 6 was dishonest, in that you knew you did not have the necessary competencies relating to IV administration;

8. On 22 November 2018, acted unprofessionally, in that you;
    a. Arrived at the Trust around 09:10 when your shift started at 08:30;
    b. Did not notify anyone that you would be arriving late;
    c. Heated and then ate breakfast instead of beginning working;
    d. Ate breakfast in a clinical treatment room that should be kept sterile;

9. On 22 November 2018, failed to carry out appropriate IV administration, in that you;
    a. Had to be corrected and/or prompted by ZH, a colleague, in your aseptic technique when preparing the IV antibiotics;
    b. Failed to identify the difference between a securacath and a clamp;
    c. Had to be told by ZH to move the tray closer to you to reduce risk of contamination;

10. On 23 November 2018;
    a. Attempted to administer subcutaneous heparin in the wrong part of the patient's body;

b. Failed to first gain said patient's consent;
c. When the patient raised the mistake, glared at them, and did not apologise;
d. Failed to check the patient record and/or the authorisation to administer medication;
e. Failed to follow handwashing procedure;
f. Failed to include the medication batch number and expiry date in the patient records;

11. On 29 November 2018, during a triage shift;
    a. Told LC2 that you needed a 10-minute break to make a call but did not return for over an hour;
    b. Only returned when LC2 found you;
    c. Were dismissive when asked why you were gone for so long, and would not comment as to whether you realised how long you had gone for;

12. On 29 November 2018, in relation to Patient A;
    a. Telephoned prior to the visit, asking "I don't know where you are, do you really need a visit," or words to that effect;
    b. Failed to arrive for the visit on time;
    c. Failed to care for Patient A appropriately, in that you;
        i. Took over an hour for a simple wound dressing;
        ii. Did not take any dressings in with you;
        iii. Acted without good manners;

13. On 30 November 2018, during a patient visit, behaved rudely to an unknown patient;

14. On 30 November 2018, during a performance meeting;
    a. Refused to make eye contact with AM;
    b. Replied to AM's questions with short or one-word answers, or not at all;

15. On 12 January 2019, acted unprofessionally in a return-to-work meeting, in that you;
    a. Were rude and obstructive in responding to questions;
    b. Refused to complete the return-to-work paperwork;

16. On 13 January 2019, during triage, failed to;
    a. Ask the necessary questions;
    b. Speak at an appropriate volume and/or with appropriate clarity;
    c. Remember the patient's name;

17. On 14 January 2019, acted unprofessionally, in that you snapped at LN, telling them that it was their responsibility to check the payroll for you;

18. On 21 January 2019, acted unprofessionally, in that you ignored safety warnings regarding the use of a particular desk, instead spreading your arms all over it;

19. On 26 January 2019;
    a. Showed poor communication skills with patients;
    b. Acted in an intimidating manner, accusing a colleague of gossiping for providing necessary feedback;

20. On 27 January 2019, showed a poor and/or negative attitude to patients;

21. On 11 March 2019;

    a. Arrived at 09:35 for training that commenced at 09:00;
    b. When refused entry, said "Jesus, you told me the wrong time" or words to that effect;
    c. Acted in a manner that was aggressive and/or intimidating;

22. On 18 March 2019, failed to attend a cannulation course;

23. On 29 March 2019, failed to attend a cannulation course;

24. On 2 April 2019, in a meeting with SF, your A&E manager, acted unprofessionally, muttering “Jesus Christ”;

25. On 21 May 2019;
    a. Failed to carry out observations on patients;
    b. Told JS, a Senior Sister that you had carried out one or more observations when you had not;

26. Your conduct at charge 25.b. was dishonest in that you knew you had not completed the observation(s) but intended for SF to believe that you had;

27. On 27 May 2019, failed to provide adequate care to a patient, in that you;
    a. Took two hours to administer a prescribed medication;
    b. Failed to introduce yourself;
    c. Did not assess the patient sufficiently;
    d. Offered the patient pain relief shortly after they had received pain relief;

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

Background

Miss Adjo has been practising as a registered nurse since 2001. She faces 27 allegations arising out of her employment at Great Western Hospitals NHS Foundation Trust (the Trust).

The referral was made by Miss Adjo’s previous clinical supervisor (Witness 1) who worked with her between 5 November 2018 and February 2019, at which stage Miss Adjo was transferred to a different area in the Trust. The NMC received the referral on 11 September 2019.

At the relevant time, Miss Adjo was working at the Swindon Community Health Services (SCHS) Orbital in a Band 6 role as Rapid Response Community Intermediate Care Nurse (RRICN) but did not pass her probation. The role was in community nursing and involved visiting patients to conduct assessments after they had been discharged from the hospital.

Concerns were raised by Witness 1 that Miss Adjo had a very poor attitude, consistently arrived late and was rude, aggressive, and obstructive towards patients and colleagues. It is stated that the concerns against Miss Adjo essentially fall into three categories: professionalism; communication; and the standard of her clinical skills with an overarching concern about poor attitude.

It is alleged that Miss Adjo's communication with colleagues and patients was of concern with regard to her interaction, frequently described as rude, and examples of this included ignoring Witness 1 in formal meetings, sitting with her back turned to him and other colleagues in various settings, and that she simply did not engage with patients.

It is also alleged that Miss Adjo had informed her colleagues, including Witness 1, that she was competent in clinical skills such as wound care, Intravenous (IV) medication and catheterisation but did not provide any certification of this when requested. Feedback from clinicians who observed her were that she was not safe to practise in these areas and needed further training.

It is further alleged that Miss Adjo was not considered competent in IV medication administration and showed poor ANTT (aseptic non touch technique). Miss Adjo was observed attempting to administer a sub-cutaneous Fragmin injection to a patient's chest, rather than the lower abdomen. Miss Adjo's telephone assessments and triage advice were also considered unsatisfactory. Further, Witness 1 stated that Miss Adjo was not speaking loud enough, wasn't collecting the right information, and did not introduce herself or state her position during one of the telephone calls that was observed.

At her request, Miss Adjo was transferred on 4 February 2019 to the Emergency Department (A&E). There were further concerns during this time and Miss Adjo was managed on a Performance Improvement Plan (PIP) and a Conduct Improvement Plan (CIP). During this time, she is alleged to have displayed further intimidating and unprofessional behaviour to colleagues when attending the Trust's training academy and did not comply with the requirements regarding attendance and pre-reading to complete some of the courses she was booked to attend. She was due to have her probation extended on 18 June 2019 but left before this was completed.

Moreover, it is alleged that Miss Adjo failed to undertake patient observations when requested to do so by a Senior Sister and then falsely asserted that she had completed and recorded those observations.

Miss Adjo resigned from the Trust before completing her PIP and CIP, although some elements of the PIP had been successfully completed. The CIP elements relating to her conduct and attitude were not achieved.

Decision and reasons on facts

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

The panel has drawn no adverse inference from your non-attendance, while the majority of the NMC witnesses gave evidence. The panel accepted that you did not deliberately avoid confronting the majority of the witnesses in cross-examination, and accepted that you changed your mind about attendance at the hearing, which resulted in your full participation from 15 December 2023, after all but one of the NMC witnesses had given oral evidence. It was not submitted on behalf of the NMC that the absence of any cross-examination of those witnesses restricted your ability to give evidence disputing their account.

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 balance of probabilities test applies to a charge of dishonesty, but dishonesty should not be found proved without compelling evidence of it.

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

- Witness 1: Employed by the Trust as a Band 6 Community Charge Nurse and was Miss Adjo's clinical supervisor.
- Witness 2: Employed by the Trust as a Band 6 CICT Sister at the time.
- Witness 3: Employed by the Trust as a Band 6 Community IV Therapy Nurse.
- Witness 4: Employed by the Trust at the Team Leader for the Community Intermediate Care Team and Rapid Response Team.
- Witness 5: Employed by the Trust as a Band 6 Sister within the Community Intermediate Care Team at the time.
- Witness 6: Employed by the Trust as an Assistant Practitioner with the IV Therapy Service.

- Witness 7: The Clinical Training and Development Manager at the Dedicated Training Academy.
- Witness 8: Community Intravenous Therapy Nurse at the Trust.
- Witness 9: Community Paramedic Practitioner at the Trust.
- Witness 10: Band 7 Team Lead with Swindon Community Health Services at the time.
- Witness 11: Senior Sister and an Emergency Nurse Practitioner (manager) at the Trust.
- Witness 12: Emergency Nurse Practitioner in the emergency department at the Trust.

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

It was an important part of your case, which the panel bore in mind throughout its consideration of the charges that NMC witnesses had ganged up against you. On consideration of all the evidence, the panel was satisfied that there was no agreement among the witnesses or any section of them to gang up against you. However, the panel was satisfied that Witness 1 adopted a negative attitude towards you.

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

Charge 1

On 7 November 2018, having given that date as your start date, told LN, your line manager, that you could not stay that day, and left.

This charge is found proved.

In considering charge 1, the panel determined that 'start date' should be interpreted not as your first date of employment, which was on 5 November 2018, but on 7 November 2018. This is because 7 November 2018 was the first time when you were working with the Rapid Response/Community Intermediate Care Team (the Team) following your induction. In the panel's judgment, this would be a normal interpretation of 'start date' in this employment.

The panel heard that you were told that you had been given that date as your start date with Witness 4, who also gave evidence of a conversation between you and her on 7 November 2018. She stated that you told her, you had to leave because you had a meeting in London. In your evidence to the panel, you said that you had attended work on that day and that no conversation had taken place between you and Witness 4 on this subject. You said that you did not have a meeting in London at that time. Your case was that you had worked that day and that the allegation made against you was untrue.

The panel was satisfied with Witness 4's evidence. She gave oral evidence in accordance with her witness statement. There was documentary evidence of a further meeting between Witness 4 and you on 9 November 2018 in relation to your attendance. It is inherently unlikely that at this very early stage in your employment animosity would have arisen between you and others working at the Trust, which would give rise to a suspicion of concocting an allegation against you. The evidence that you left is based on Witness 4's written statement.

In considering the documentary evidence relating to this charge, the panel paid close attention to a document titled 'Ethel Adjo training schedule' (Training Schedule) for the month November 2018. This was produced by you for the first time during the course of your oral evidence. The entry for 7 November 2018 is 'D/O'; it was agreed that this

should be interpreted as day off. Based upon both your evidence and the evidence of Witness 4, the panel is satisfied that the day of recording was 7 November 2018 and it was not the original plan for your training, but was amended subsequently because you did not attend on 7 November 2018.

Having taken all of the above into consideration, the panel determined that you attended early on 7 November 2018, that you told Witness 4 that you would leave, and you then left. Accordingly, this charge is found proved.

Charges 2a, b and c

On 14 November 2018;

a. Failed to obtain the consent of an unknown patient before carrying out care;
b. Failed to wash your hands and/or put on gloves before checking a pressure ulcer;
c. Failed to clean equipment after using it;

These charges are found NOT proved.

The panel considered the evidence of Witness 1, detailed in his note book. In your Training Schedule, you are shown as shadowing Witness 1 as it was your first day.

Witness 1 made copious notes on this day. However, his notes did not bear out these charges as one might expect. The fact that all the criticisms contained in this charge first appear in Witness 1's written statement, which was made more than two years after the incidents alleged to have occurred, but which do not appear in the contemporaneous notes, causes the panel to conclude that the evidence in the witness statement cannot be relied upon in relation to these charges. It therefore determined that these charges are found not proved.

Charge 3a

On 15 November 2018;

a. Failed to appropriately assess an unknown patient during triage by failing to ask necessary questions.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. In his written statement he states, *'I explained that we needed to gather all of the relevant information from whoever makes the call to the Triage desk, for example from the patient, or their carer or relative, to prioritise visits accordingly.'* It also noted that Witness 1 copied in his copious note book of the expectations of the phone calls. The panel accepted the evidence of Witness 1 and determined that the triaging process pertaining to a patient who had his catheter exposed was not triaged appropriately.

The panel was of the view that it would be reasonable to expect that the nurse triaging this phone call, on hearing that a patient had expelled their catheter, to ask the questions about pain, urine output, fluid intake and whether or not they had passed any urine into the incontinence pad. Furthermore, there could be other questions pertaining to the patient's pre-existing medical condition. Dependent on the answers to these questions, the patient might need an urgent visit in order that the catheter could be replaced.

You did not put forward any positive case in either your written evidence or your oral evidence about questions which you asked on this occasion; instead, you referred to a lack of instruction from the Trust in relation to specific questions.

Having taken all of the above into consideration, the panel determined that this charge is found proved.

Charge 3b

b. Failed to make an appropriate record of the conversation, in that you;
    i. Failed to use appropriate language, referring to the patient's husband as "hubby;"
    ii. Failed to note the advice you gave during triage;

These charges are found NOT proved.

The panel determined that there is no record of your note or any document put before it which purports to record your conversation. Although Witness 1 states that a record was made by you, in your evidence, you said that you would not use the term '*hubby'*, as alleged at charge 3bi. In the panel's view, it would not be inappropriate to use a well understood slang word for husband, whether or not you used it.

In relation to charge bii, you said that you do not know what it meant by that allegation. In the absence of any written record being placed before the panel, it was unable to conclude that the advice you gave during triage was not noted as it should have been. It therefore found these charges not proved.

Charge 4a

On 19 November 2018;

a. Told AM, your clinical supervisor at the time that that you were competent in catheterisation, tissue viability, insulin and IV administration.

This charge is found NOT proved.

The panel noted that you told AM (Witness 1) that you were competent in female catheterisation. You said that you considered that tissue viability was a specialist area of nursing, which you did not have. You stated in your written submissions that *'[Witness 1] did not ask me nor speak to me on this date about insulin. I do not remember anything of the sort'.* The panel noted that charge 4a goes much further than what your evidence was directed to. The panel had to determine whether you said that you were competent in the named listed skills, viz. catheterisation, tissue viability, insulin and IV. Nowhere in Witness 1's contemporaneous notes of conversation relating to this matter are any of those four items listed. They appear for the first time in Witness 1's written statement, which was made two years after the event.

Moreover, it is part of the NMC's case, as shown at charge 4c, that on the same day you told a colleague that you believed only doctors could change suprapubic catheters; which is inconsistent with what you are alleged to have said at charge 4a. Your evidence as to what you said about competencies is more specific than Witness 1's contemporaneous notes which refer to your claim to be competent in everything. Based on these pieces of evidence, the panel is not satisfied that you made the full statement set out at charge 4a. Accordingly, the panel determined that charge 4a is found not proved.

Charge 4b

b. Failed to provide these competencies to AM at any point following that conversation.

This charge is found proved.

The panel noted that Witness 1 was your supervisor and there was a requirement for you to provide those competencies to him. In your evidence, you said that there was a problem in doing so because your possessions had been packed up as you were moving house. It is not in dispute that you did not provide the document sought of you during the course of your employment. Consequently, the panel determined that charge 4b is found proved.

Charges 4c and d

c) Told LC2, a colleague, that you believed only doctors could change suprapubic catheters.

d) Acted unprofessionally, in that you tried to persuade LC2 to let you change the catheter when you were not signed off in front of the patient.

These charges are found proved.

In relation to charge 4c, the panel noted that in your written submissions to the NMC in of advance of this hearing, you admitted to making this statement to Witness 5. You

stated that, *'In my experience, [insertion] of supra pubic catheter is only done by Drs unless a person is specially trained to do this.'*

In relation to charge 4d, the panel had sight of the email from Witness 5 dated 22 November 2018, where she provided evidence of the conversation that took place in front of the male patient when you were persistent in seeking to carry out the procedure of catheter change. Witness 5 stated, '*in front of the patient Ethel told me [Witness 1] had said she could be signed off if she was watched. I repeated that she would need the training before she reached that stage and I would do the change today. Ethel wouldn't leave conversation at this…'*

The panel is persuaded that this entire conversation did take place within the earshot of the patient and in his presence. It determined that your conduct was unprofessional and therefore found these charges proved.

Charge 5

> Your conduct at charge 4a was dishonest, in that you knew you did not have the necessary competencies relating to catheterisation and/or IV administration;

This charge is found NOT proved.

This charge is found not proved because the panel did not find charge 4a proved.

Charge 6

> On 21 November 2018, confirmed to AM that you had IV administration competencies.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and noted that it has always been your case that you had IV administration competencies. Shortly after the panel had retired to discuss the facts, with the agreement of Mr Rye, you produced an IV training certificate dated 21 April 2018, which showed that you do indeed have IV

administration competencies. Having taken that into consideration, the panel determined that this charge is found proved.

Charge 7

Your conduct at charge 6 was dishonest, in that you knew you did not have the necessary competencies relating to IV administration.

This charge is found NOT proved.

This charge is found not proved. The panel has determined that you have established clearly that you had the necessary competencies relating to IV administration, as set out in the previous charge.

Charges 8a and b

On 22 November 2018, acted unprofessionally, in that you;

a. Arrived at the Trust around 09:10 when your shift started at 08:30;
b. Did not notify anyone that you would be arriving late.

These charges are found NOT proved.

In reaching this decision, the panel took into account your evidence, the evidence of Witnesses 6 and 8. In her written statement, Witness 6 stated, *'Nurse Adjo was due to arrive at the Clinic on 22 November 2018 to start their supernumerary shift at 08:30, however, they did not arrive until 09:10, 40 minutes late.'*

Witness 8 stated in her written statement, *'On 22 November 2018, Nurse Adjo arrived 40 minutes late to their shift at the Clinic. They were due to be going out on home visits with me first thing in the morning. Nurse Adjo being late disrupted my whole working day, as it meant I started 40 minutes behind without encountering any other difficulties.'*

In your written submissions, you stated that, '*Whilst I do not specifically recall 22 November 2018, I believe I was late on some occasions during my time working at the*

Great Western Hospitals NHS Foundation Trust and, on any of the occasions, I phoned to let them know I would be late.'

The panel was satisfied that you arrived late, as alleged in the charge. The panel has given careful consideration as to whether you had acted unprofessionally in this situation. As you were running late, you were under an obligation to notify the Trust that you would be arriving late.

The panel was of the view that in order to make out this charge, it would have to be shown that no message whatsoever was notified to the Trust that you would be arriving late. The panel is satisfied that Witness 8 did not receive a message that you would be arriving late, but that is not the same as establishing that no message was left. Your evidence was that you did indeed leave a message. In these circumstances, the panel is unable to conclude that you did not notify *'anyone'* that you would be arriving late, and accordingly, that you were acting unprofessionally.

The panel therefore determined that charges 8a and b are found not proved.

Charges 8c and d

c. Heated and then ate breakfast instead of beginning working;
d. Ate breakfast in a clinical treatment room that should be kept sterile;

These charges are found proved.

In reaching this decision the panel took into account your evidence and the evidence of Witness 8. In her written statement, Witness 8 stated that, *'At this point Nurse Adjo, who was in the staff room, took out some food, put it in the microwave then started to eat. I told Nurse Adjo again that they were running late and needed to leave for the home visits. Nurse Adjo responded that they had not had their breakfast yet. I was concerned that Nurse Adjo was more focused on having their breakfast than starting the shift that they were already running 40 minutes late for.'*

The panel noted that Witness 8 gave direct evidence that you were heating up your pasty which was wrapped in a serviette, having arrived at work late and then proceeded

to take it to the clinical room where you were eating it. Witness 8 provided evidence that you were challenged for sitting and eating in the clinical room when you were expected to go out.

You stated in your written submissions that, *'I deny the charge that on arrival at work I heated and then ate my breakfast in the clinical room. The roll I brought is a cold one. And it is normal for community nurse to carry their food with them as sometimes you will not get the chance to have a proper break when one is running between patients with traffic. I was holding my food because the person I was going out with was in the clinical room, not ready for us to go.'* In your oral evidence, you stated that you '*broke off a corner'* of your Ginsters pasty. The panel noted that this was contradictory to what you stated in your written submissions.

Having considered all of the above, the panel determined that these charges are found proved.

Charge 9a

On 22 November 2018, failed to carry out appropriate IV administration, in that you;

a. Had to be corrected and/or prompted by ZH, a colleague, in your aseptic technique when preparing the IV antibiotics.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 3 (ZH) and 8. The panel has considered that this charge relates to one of the competencies in IV administration. Witness 3 stated, *'I am aware that following our recommendation, Nurse Adjo was booked on to PICC training on 10 December 2018 and IV administration training on 14 January 2019. Nurse Adjo was also due to return to the Clinic to be observed and signed off as competent following the training on 16 January 2019.'* Following this incident the Trust decided that you needed to do further training which was booked for 10 December 2018 and this further demonstrates that you needed to be updated.

The panel noted that you challenged Witness 3 in the Aseptic None-Touch Technique (ANTT) on the basis that it was different to that you were used to. The panel heard that there was a recognised difference in the techniques applied. However, Witness 3 had to prompt you to apply the technique that is adopted by this Trust in preparing the IV antibiotics. This is supported by an email sent by Witnness 8 to Witness 4 dated 23 November 2018. Witness 8 stated that, *'Ethel accompanied [Witness 3] out on a home visit to administer IVABX via PICC yesterday afternoon. Ethel did challenge [Witness 3] on the way we practice but was accepting of Zoe's reasoning. [Witness 3] was able to observe Ethel and unfortunately there were a few issues identified…*' This email was completed by way of support and understanding of your competence.

Having considered the above, the panel determined that this charge is found proved.

Charge 9b

b. Failed to identify the difference between a securacath and a clamp.

This charge is found proved.

The panel heard that you failed to identify the difference between a securacath and a clamp. It noted that Witness 3 stated, *'The patient who we were visiting to administer the IV antibiotics had a securacath on their PICC line. Nurse Adjo seemed confused about the difference between a securacath and a clamp.'*

During your oral evidence you were easily able to explain what your position was. However, for whatever reason you were not forthcoming in your communication with Witness 3. The panel was satisfied that you were aware of the difference because you had been certified competent. However, for some reason on this occasion you had not demonstrated it to your colleague who was supporting you on the day.

Having considered the above, the panel determined that this charge is found proved.

Charge 9c

c. Had to be told by ZH to move the tray closer to you to reduce risk of contamination;

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Witness 3. You stated in your written submissions, *'I do not recall [Witness 3] informing me to move the tray closer to reduce the risk of contamination. Again, different nurses and Trusts carry out procedures in different ways but that does not necessarily mean that one way is wrong and the other right. I carried out this procedure correctly and nothing did increase the risk of contamination.'*

The panel understood that the tray in this charge constituted the sterile field for this procedure. Therefore, it accepted that it is a good practice to have the sterile field as close to the patient as possible and that you were under observation for competencies as a new member of the team and it is expected that you would have performed to demonstrate those competencies.

Having taken this into consideration, the panel determined that this charge is found proved.

Charge 10a

On 23 November 2018;

a. Attempted to administer subcutaneous heparin in the wrong part of the patient's body.

This charge is found proved.

After the evidence had been given, Mr Rye pointed out that the relevant drug was said to be heparin in charge 10a, but in the evidence the drug was referred to as fragmin. The difference in terminology was discussed by you and the panel. It was common ground between you and the registrant member of the panel that heparin and fragmin

had the same purpose. In those circumstances, the panel did not deem it necessary to amend the charge.

The panel noted that there is evidence to demonstrate that you were upset at this point, and in the panel's judgement, Witness 1 at this time was also upset by the complaint and the criticism made against him by you. For your part, you were upset by what you regarded as a persistently negative attitude by Witness 1 against you. In this situation, Witness 1 was making very detailed notes about you, which raised points of criticism against you in relation to anything which he perceived was not up to standard. There appears to have been little or no acknowledgment of anything good in your performance. As a result of this atmosphere, the panel regarded it as likely that your level of performance was not what it usually would be.

The panel considered that it is incorrect to administer such an injection into the chest wall. However, the panel determined that such an unusual error would be more likely if you felt unhappy and under pressure in the presence of a supervisor who was critical of you and who you felt was not supportive.

Furthermore, the panel is satisfied by the graphic description by Witness 1 of the patient intervening to ask you not to inject him in the chest when injections were normally administered to the abdomen, with the patient having to explain the procedure. This is unlikely to have been concocted in the contemporaneous notes made by Witness 1. He stated in his written statement, *'she attempted to give this in patient's upper body. The patient appeared shocked and pointed to his lower abdomen and said it goes in here.'* He confirmed his account during his oral evidence.

The panel was persuaded by the detailed and comprehensive notes of Witness 1, which were contemporaneous, that it did happen. Having considered the above, the panel determined that this charge is found proved.

Charges 10b, c and d

b. Failed to first gain said patient's consent;

c. When the patient raised the mistake, glared at them, and did not apologise;
d. Failed to check the patient record and/or the authorisation to administer medication.

These charges are found proved.

The panel noted that the supportive evidence for the above charges feature in Witness 1's contemporaneous notes. There was a clear expectation that you should gain the patient's consent before trying to inject the patient. In evidence, Witness 1 stated that you did eventually gain the consent before actually going on to administer the injection. Witness 1 described your demeanour as follows: ''*Apologised to patient and from Ethel's facial expression she appeared unhappy that I had apologised.'*

In relation to charge 10d, Witness 1 stated, '*she did not know what an authorisation to administer medication was, did not understand this form…'*

The panel found proved that you failed to check the authorisation to administer the medication, based on the evidence of Witness 1. However, the panel was not satisfied that the patient records element of this charge was made out.

Having considered all of the above, the panel determined that charges 10b and 10c are proved in their entirety; and part of 10d is proved, namely that you failed to check the authorisation to administer medication.

Charge 10e

e. Failed to follow handwashing procedure.

This charge is found proved.

The panel noted that you deny this charge and explained in evidence that you were previously a champion in infection control. You also said during your oral evidence that *'not washing hands is a demeaning character to person like me.'* The panel

considered the detailed notes compiled by Witness 1 which show that you failed to follow the handwashing procedure. Having considered the evidence, the panel determined that this charge is found proved.

Charge 10f

f. Failed to include the medication batch number and expiry date in the patient records;

This charge is found NOT proved.

The panel accepted that you had to be reminded that the medication batch number and the expiry date were not updated in the patient record as expected. It is highly unlikely that this would not have been subsequently completed. In the notes of Witness 1, he said that after your mistake had been pointed out to you, you made a grunting noise and raised your eyebrows.

The panel formed a view that without further documentary evidence of this patient record, it cannot be satisfied that you did not then complete the patient records to include the medication batch number and the expiry date. It therefore found this charge not proved.

Charges 11a, b and c

On 29 November 2018, during a triage shift;

a. Told LC2 that you needed a 10-minute break to make a call but did not return for over an hour;
b. Only returned when LC2 found you;
c. Were dismissive when asked why you were gone for so long, and would not comment as to whether you realised how long you had gone for'

These charges are found proved.

The panel heard the evidence of Witness 5 (LC2) whom it found was consistent with her contemporaneous email notes dated 29 November 2018. Witness 5 stated in her written

statement, *'Nurse Adjo told me that they needed to go to the staff room and make a call, they said they would be 10 minutes… I then noticed that Nurse Adjo had not returned and saw that it had been an hour since they left.'*

The panel found it reasonable to have a ten minutes break. However, Witness 5 stated that she had been working for an hour, had observed the time and because she was so concerned, she went looking for you but you became annoyed that you were interrupted in the toilet.

The panel noted that you were challenged in the performance meeting held by Witnesses 1 and 10, on 30 November 2018, about your absence from the triage shift the previous day. You referred to making a phone call to IT and were trying to sort out the computer for work which is endorsed by you on that same day.

In your oral evidence, you disputed that account and said that you were not gone for an hour. You accepted that you were in the toilet but found it unacceptable to be disturbed. Further, you accepted that you had gone for a while but not that long and that you were not making a phone call to IT on that occasion.

The panel considered your oral and written evidence. It noted that in your written submissions you have stated, *'I have no recollection of this incident with [Witness 5]. I do however recall that [Witness 5] would come and knock on the toilet door when I was at the toilet.'* However, in your oral evidence you agreed that you had been in the toilet but that you were not on the phone to IT and that you had not gone for that long.

The panel preferred the evidence of Witness 5 who had made notes about this incident at the time. When you were challenged by her, you were dismissive about how long you were gone for. The panel deemed that it is perfectly acceptable to be unaware sometimes when on the phone about how long a call was. However, you did not provide an explanation for your absence.

Having considered all the evidence, the panel determined that charges 11a, b and c are found proved.

Charge 12a

On 29 November 2018, in relation to Patient A;

a. Telephoned prior to the visit, asking “I don’t know where you are, do you really need a visit,” or words to that effect.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 10. In her written statement, she stated, ‘*The patient said that Nurse Adjo did not appear to know what they was doing. They said Nurse Adjo was running late to see them and they had phoned the patient and asked whether the patient really needed a visit. The patient said they did need a visit. When Nurse Adjo visited the patient, the patient said Nurse Adjo was asking them what dressing they required on their foot.’*

The panel has assessed the continuity of hearsay evidence provided by Ms 1 dated 30 November 2018, the day after the alleged incident where three key points are referred to by Witness 10, who later spoke with Patient A to address the concerns raised.

The panel heard that Patient A had been allocated to you because the other nurses were busy and it was deemed a relatively straightforward visit. The panel was satisfied, based on two witness accounts, who independently spoke to the patient, that it is unlikely that the patient would raise this issue with two independent nurses unless it was true.

In your evidence you stated that you attended this visit but that Patient A told you that they were expecting a visit the previous day and this is why they were unhappy.

Having considered the evidence, the panel determined that this charge is found proved.

Charge 12b

b. Failed to arrive for the visit on time.

This charge is found NOT proved.

The panel determined that there is little or no evidence to indicate what actual time that you could be said to have committed to visiting Patient A. Moreover, in the email of Witness 10, criticism is made of your performance on this occasion but the question of your arriving late is not raised. The panel therefore found this charge not proved.

Charge 12ci

c. Failed to care for Patient A appropriately, in that you;
    i. Took over an hour for a simple wound dressing.

This charge is found NOT proved.

This charge is about the appropriateness of care to Patient A by you. The evidence comes from a disgruntled patient who you say was expecting a visit the previous day. In this instance, System One (the patient electronic health record) was down and it is alleged that you took over an hour for wound dressings. The panel has no other records to establish what level of other treatment you may or may not have applied during that hour, and there is no evidence from any other professional to establish the seriousness of the wound which you were required to dress. Accordingly, the panel determined that this charge is found not proved.

Charge 12cii

ii. Did not take any dressings in with you.

This charge is found NOT proved.

The panel noted that you accepted that you left the dressings in your car. The panel is not satisfied that your needing to go to you car constituted a failure to care for patient A appropriately. Apart from any other consideration, you might reasonably have expected the patient, who had previously required their wounds to be dressed, would have dressings in their home. Accordingly, this charge is found not proved.

Charge 12ciii

iii. Acted without good manners;

This charge is found NOT proved.

The panel determined that there is insufficient evidence to show how you have not demonstrated good manners and consequently it found this charge not proved.

Charge 13

On 30 November 2018, during a patient visit, behaved rudely to an unknown patient.

This charge is found NOT proved.

The evidence adduced by the NMC is solely given by Witness 4, who referred to a patient's complaint that you behaved rudely. There is no evidence before the panel to determine how you had behaved rudely or the identity of this patient. Consequently, this charge is found not proved.

Charges 14a and b

On 30 November 2018, during a performance meeting;

a. Refused to make eye contact with AM.
b. Replied to AM's questions with short or one-word answers, or not at all;

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 1. In his written statement, Witness 1 stated, *'At the meeting Nurse Adjo spoke directly to [Witness 10] but ignored me and would not make eye contact with me.'* It also considered the evidence of Witness 10 who stated in her written statement, *'During the meeting I did witness concerns regarding Nurse Adjo's attitude towards [Witness 1]. Their general demeanour towards him was concerning in that they did not make eye contact with him and would not respond to any questions asked by [Witness 1]. If they*

did respond to Nurse [Witness 1] they were very short responses or one word answers. Nurse Adjo did not have the same demeanour towards me.'

The panel noted that you deny charge 14. However, as the panel has explained above, by this date relations between you and Witness 1 had broken down, because of your complaint about him and his many criticisms against you. Accordingly, the panel is satisfied that Witness 10's account that you would not make eye contact with Witness 1 and that you answered his questions very briefly or not at all, is probably correct. Your demeanour in relation to Witness 1 contrasted with your more positive behaviour towards Witness 10, who was running the meeting. Accordingly, charges 14a and b are found proved.

Charges 15a and b

On 12 January 2019, acted unprofessionally in a return-to-work meeting, in that you;

a. Were rude and obstructive in responding to questions;
b. Refused to complete the return-to-work paperwork;

These charges are found NOT proved.

In deciding these charges of acting unprofessionally in a return to work meeting, it is clear that there had been heated exchanges between you and Witness 1, and that you were clearly upset as you have indicated on the Return to Work Meeting Form which you refused to sign. Witness 1 in his written statement states, *'At one point Nurse Adjo stormed out of the room. Nurse Adjo declined to sign the RTW paperwork and the meeting was ended abruptly.'*

The obstruction and rudeness charge levied at you is based on allegations that Witness 1 states are made against him and Witness 4. It is clear that this was not a cordial meeting but if, as is alleged, you were rude and obstructive in this meeting, it is unclear whether such rudeness and obstructiveness related to responding to questions. Insufficient detail is given in the NMC's case. You deny the charge. The panel does not accept that you acted unprofessionally in these circumstances by refusing to complete

the Return to Work Form, as you did not agree with its contents. Furthermore, the same paperwork remains unsigned by the other participants of the meeting. Accordingly, the panel finds charges 15a and b not proved.

Charges 16a, b and c

On 13 January 2019, during triage, failed to;

a. Ask the necessary questions;
b. Speak at an appropriate volume and/or with appropriate clarity;
c. Remember the patient's name.

These charges are found proved.

The panel considered the evidence of Witness 2 and had been supplied with the Standard Operating Procedure (SOP). Witness 2 provided the expectations of the nurse triaging a telephone call as: '*When triaging it is our responsibility to review the patients' notes on the system we use and then call the patient/carer/relative and triage. With the information obtained from reviewing the notes and speaking to the patient/carer/relative we create a care plan, allocate a visit to the patient and inform the caller of this plan.*'

In her written statement, Witness 2 stated, *'Nurse Adjo failed to ask basic questions about why the carer had called in, and obtained no new information to appropriately allocate the call.'*

The panel heard the audio file which was also played to you during panel questions. It is clear from the audio file that all parties can be heard, including the caller and you, albeit faintly, at first. You had to be prompted a number of times to speak up so that the caller can hear you. You got the patient's name wrong twice before you got it right on the third occasion when the name was provided correctly with the assistance of the caller. During the call, you cannot be heard to ask any questions. The panel was of the view that there would be necessary questions that should have been asked. Upon questioning from the panel, you stated that your voice was low and it is not what you expect of yourself, you had triaged before and that you could have asked more questions.

Accordingly, the panel found charges 16a, b and c proved.

Charge 17

On 14 January 2019, acted unprofessionally, in that you snapped at LN, telling them that it was their responsibility to check the payroll for you;

This charge is found proved.

The panel was of the view that there was an expectation when discussing personal and professional concerns that those meetings should be conducted both calmly and professionally. Witness 4 had made a note of this Return to Work Meeting on 24 Jan 2019 where she said *'she snapped and said she done her bit now and it was up to me..'* This was when Witness 4 was trying to support you in relation to a concern you had around unpaid day(s).

In evidence, Witness 4 told the panel that there was a conversation between you and her where she sought to support you and contacted payroll on your behalf. Witness 4 was unable to conclude satisfactorily because payroll insisted on dealing only with employees i.e. you. She stated that you were very snappy and that she remained polite throughout. Witness 4 further stated that she felt physically sick and called her manager because she never felt like that before.

You disputed this and stated that you remained professional throughout but merely explained to Witness 4 what payroll told you as to why you did not get paid.

The panel preferred the evidence of Witness 4 who was able to give a much detailed and specific account of the meeting. The panel concluded that you snapped at Witness 4 when she was trying to assist you; which it considered to be unprofessional. The panel recognised that a matter relating to pay is likely to be very important to you but does not justify unprofessional behaviour in a work environment.

Having taken all the above into consideration, the panel determined that this charge is found proved.

Charge 18

On 21 January 2019, acted unprofessionally, in that you ignored safety warnings regarding the use of a particular desk, instead spreading your arms all over it

This charge is found proved.

The panel heard from two witnesses in relation to this charge. Witness 1 stated in his written statement, *'Nurse Adjo asked where she should sit and I pointed to an area where there was a free desk. She pointed to a desk which was closer to her. I explained that there had been a leak from the ceiling above that desk and that it was not safe to sit there as water had leaked onto the table and under the computer base and socket extension. Nurse Adjo ignored me, turned her back to everyone and spread her arms out on the whole desk.'*

The panel noted that Witness 2 corroborated this account and in evidence drew a diagram for the panel which showed you were facing the corner of the room where a bucket was drawn on the desk. She stated that you had your back towards the room and your colleagues. Witness 4 also stated that you sat down with your arms spread and elbows wide across the desk. You were asked about this in evidence and denied that you would ignore the safety advice. In your written statement, you stated, *'I would not have ignored safety warnings given to me by colleagues. I feel this is an example of the petty way in which I have been pursued by my former colleagues. In that room people wouldn't ask to sit down, they would just sit down where there's a space and of course who will want to be wet if the roof is leaking where I was then I don't even need anyone to prompt me to get off the place.'*

The panel preferred the evidence of Witnesses 1 and 2, and was satisfied that your conduct was unprofessional in ignoring the safety warning. It therefore found this charge proved.

Charge 19a

On 26 January 2019;

a. Showed poor communication skills with patients.

This charge is found NOT proved.

In relation to charge 19a, the panel considered the evidence of Witness 9 who stated, *' Nurse Adjo's communication with patients was also poor*.' The panel noted that it is alleged that you had poor communication skills with patients. However, it was unable to find any specific evidence that shows your poor communication skills with patients. This is the extent of the evidence in relation to this charge and the panel has no other clear evidence to show how you have communicated poorly with patients. The panel therefore found this charge not proved.

Charge 19b

b. Acted in an intimidating manner, accusing a colleague of gossiping for providing necessary feedback;

This charge is found NOT proved.

The panel considered the evidence of Witness 9 who made contemporaneous notes following the visit that feature in an email dated 27 January 2019 which make reference to her being accused by you as being a gossip. Witness 9 stated in the email, *'I told Ethel that if I had an issue with her, I would speak to her at the time, I am not a gossip and was insulted that she would say that about me.'*

The panel accepted that you accused Witness 9 of gossiping about you. However, apart from the mere statement that Witness 9 felt intimidated, there is no evidence that you acted in an intimidating manner, which is the thrust of this charge. An individual's perception that they felt intimidated without any supporting evidence that your behaviour was intimidating is insufficient to enable the panel to conclude that you acted in an intimidating manner. Accordingly, this charge is found not proved.

Charge 20

On 27 January 2019, showed a poor and/or negative attitude to patients.

This charge is found NOT proved.

In reaching this decision, the panel considered the evidence of Witness 1, which was based on hearsay. The panel could not find any reference from Witness 8 to support this charge. Witness 8 provided comprehensive notes of her interaction with you on 26 and 27 January 2019. However, in reference to 27 January 2019, there is no reference to your poor negative attitude to patients. Witness 8 stated in her email dated 27 January 2019, *'we went on a visit and Ethel said she didn't feel well. When back at the office I passed this on to [Witness 9] and [Witness 9] sent her home. This was at 11:45.'* The panel determined that this suggests it was a very short interaction on that morning.

The panel took into account that you stated in your written submission, '*I deny this charge and note there are no specifics in the statement about what is said to be my poor attitude.'*

In the absence of any substantial evidence supporting this charge, the panel determined that this charge is found not proved.

Charge 21a

On 11 March 2019;

a. Arrived at 09:35 for training that commenced at 09:00;

This charge is found proved.

In reaching this decision, the panel considered the document titled 'Memorandum', 'Re Male Catheterisation' which states in bold 'here are 3 simple steps for attending your clinical skills course.'

There is evidence that shows the existence of training and other delegates nurses had turned up for that training. The panel noted that it is clear that there was a training session commencing at 09:00 and as a professional nurse it would be expected that

you would know the start time and if indeed you were unaware, then you would seek to establish the start time.

The panel had sight of an email from the Training and Development Manager, Witness 7, dated 18 March 2019 which states, *'The system also generates an automatic email when a booking is made and she will have been in receipt of this. She replied that it was car parking that had held her up.'*

In your evidence, you denied this charge and stated that the only evidence against you is hearsay.

It is clear to the panel that you were late and that you would have known as this was training that was most necessary for you to continue your role as a nurse in the Team. Furthermore, you have acknowledged that you were previously late on some occasions. Accordingly, the panel found this charge proved.

Charge 21b

b. When refused entry, said "Jesus, you told me the wrong time" or words to that effect;

This charge is found proved.

Following your refusal to being admitted to the training, you then went to the administration office where you made the comments in this charge. You were heard by Witness 7 to say *'Jesus you told me the wrong time,'* to the administrator. You told the panel that you are a religious person and therefore would not use such language.

The panel accepted the detailed evidence of Witness 7 on this matter and determined that this charge is found proved.

Charge 21c

c. Acted in a manner that was aggressive and/or intimidating;

This charge is found NOT proved.

You told the panel that you would not act in an aggressive or intimidating manner because of your faith. The panel found that you would have been upset that you were not able to attend the training and you knew that you needed to complete this which gave rise to your response. Witness 7 states that *'On this occasion, I did not feel able to leave the office until she had left as […] was upset this and I felt that Ethel's behaviour was quite aggressive and somewhat intimidating.'*

The panel accepted that Witness 7 interpreted your behaviour as quite aggressive and somewhat intimidating. However, there is nothing in evidence that shows your actions to be objectively so.

Having considered all the evidence, the panel determined that this charge is found not proved.

Charge 22

On 18 March 2019, failed to attend a cannulation course.

This charge is found proved.

In reaching this decision, the panel considered the document titled *'Memorandum', 'Re IV Venepuncture & Cannulation Study Day'* which states in bold 'here are 3 simple steps for attending your clinical skills course.'

The panel determined that it is clear from the evidence that you did not complete the pre-course workbook as required. The panel also considered the notes from Witness 7 where she states *'On arrival although she was punctual, she was asked by […] whether she had completed the pre-course workbook. Initially she said she had and then changed her mind to say that she had not as she was unable to log on to training Tracker.'*

You initially stated that you had completed the pre-course work. Despite your turning up on the day, you could not complete this practical course as expected, as in fact you had failed to complete the pre-course workbook. The panel was satisfied that you were therefore unable to attend the training as you had not followed the instructions which state 'attend your practical course and bring your training tracker certificate with you proof of completion of pre-course work.' This is notwithstanding the fact that you turned up on the day.

Accordingly, the panel determined that this charge is found proved.

Charge 23

On 29 March 2019, failed to attend a cannulation course;

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 7 that there was a course which was discussed with you in a performance meeting on 2 April 2019. A note is made by Witness 11 which states *'…DNA Friday 29th March cannulation course 09.00-13.30. Ethel replied via email to academy 'sorry […] I was disappointed to myself on this occasion, So sorry Ethel'. On discussion Ethel has verbalised that she was too tired to come in. She had finished a night duty Thursday morning, and the study was Friday morning.'* The panel noted that there is no response from you in relation to this charge other than that you deny it. The panel is satisfied, on evidence from Witness 11, that a performance meeting took place where your failure to attend the cannulation course on 29 March 2019 was discussed and that the course was due to go ahead. The panel was of the view that from the note, it appears that you were aware that you should have been at that course and you could have made alternative arrangements to attend it.

Accordingly, this charge is found proved.

Charge 24

On 2 April 2019, in a meeting with SF, your A&E manager, acted unprofessionally, muttering “Jesus Christ”;

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 11 (SF) who stated in her contemporaneous notes dated 2 April 2019 that, *‘As for saying ‘Jesus you told me the wrong time, Ethel says she normally quotes this as she is a Christian and could not see what the problem is.’* The panel also took into account your evidence. In your written submissions, you stated, *‘Ms [Witness 11] was my manager. I would not have used that word.’*

The panel noted that in another meeting with your manager, Witness 11, it appears that that kind of terminology was used again. It also noted that you were being overly scrutinised but there is a duty on the manager to carry out their role. It seems as a result of the scrutiny you tended to use such unacceptable and unprofessional words.

In your evidence you said you would not use Jesus’s name in vain. However, despite your denials of use of these words, the panel has heard evidence where similar words were used by you on 11 March 2019 witnessed by another person. It therefore finds that, on balance, it is more probable than not that you used these terminologies. It therefore found this charge proved.

Charges 25a and b

On 21 May 2019;

a. Failed to carry out observations on patients;
b. Told JS, a Senior Sister that you had carried out one or more observations when you had not;

These charges are found proved.

The panel noted that the only evidence in relation to these charges come from Witness 12 who was responsible for this department as the nurse in charge on 21 May 2019. The panel found her evidence to be credible and that she had to challenge both you and your colleague during the shift. You were responsible for two of the four patients. Witness 12 stated that she challenged you regarding the incompletion of necessary paperwork and in conducting the patient observations. Witness 12 raised this concern with your manager, Witness 11, in an email dated 23 May 2018 and stated *'when checking Ethel Adjo area I found both patients documentation incomplete with observations 2 hours 20 mins late. She was working in 11-15 which she was sharing with [another nurse] resulting in her only looking after 2 patient…'*

The panel heard that Witness 12 was less concerned with the lateness with the observations but rather that you claimed to have adopted the observations, which the witness herself initialled, as yours. This observation chart is not available to the panel. However, Witness 12 made contemporaneous notes following a discussion with your manager, Witness 11. Witness 12 stated in the email, *'I went to walk back to the board, where Ethel… then walked back up to me saying that she had completed the observations pointing at the observations I had just taken. I looked and said I would check the signature before you claim to have taken these observations as that my signature as I have just completed them as they were so far behind. She laughed this off and said oh. I told her to be careful before she lies to me as that is not acceptable.'* The panel noted that this was recorded two days later, following the discussion with Witness 11.

In evidence it was established from Witness 12 that the board was the observation chart board at the end of patient's bed. The panel noted that criticism of you was balanced by the report of your improved performance recorded by Witness 12 in her email to Witness 11.

In your evidence, you deny this charge. You raised the issue that the observation chart was not produced and therefore there is no evidence for this. You said *"lying would not be me."*

In your written submissions you provided an explanation that you were writing down when the next observation was due. You stated in your written submissions '*I bitterly deny as no one called for this any time.'*

It would have been preferable for the observation chart to have been put in evidence, as that would have been the best evidence of its contents. The panel took into account the legal assessor's advice to exercise caution in relying on evidence which did not include the observation chart, which would normally be part of the evidence adduced by the NMC where its contents were crucial.

However, the nurse in charge had a strong recollection of this incident supported by contemporaneous notes following a conversation in which she raised this concern with your manager. The nurse's criticism of your incomplete observations was balanced by positive comments about you in her email. The panel concluded it could safely rely on that evidence. The panel determined that you had not carried out these observations and that you told Witness 12 that you had done so when you had not.

Accordingly, the panel found charges 25a and b proved.

Charge 26

> Your conduct at charge 25.b. was dishonest in that you knew you had not completed the observation(s) but intended for SF to believe that you had;

This charge is found proved.

This is a dishonesty charge. The panel was advised by the legal assessor that before finding dishonesty proved, it must be satisfied that there is compelling evidence of dishonesty, rather than other explanations, such as an innocent or careless mistake. The panel concluded that those patients could have deteriorated in those two hours

when you failed to record their observations. It accepted the evidence of Witness 12 who carried out the observations, following which she had initialled the patient records with her large initials. In these circumstances the panel determined that there could be no confusion who carried the observations.

Furthermore, Witness 12 said that she challenged you when you sought to claim that you had carried out the observations and that the initials on the chart were your own. You knew that you were expected to carry out those observations for those patients, it was raised with you that you had not done and were given more time to do so. Witness 12 noticed that they were still not done, therefore she went and done it herself. The panel determined that by your own actions, in relation to charge 25b, you knowingly acted dishonestly. Your conduct was dishonest by the standard of ordinary decent people.

The panel determined that you tried to claim that it was you who did the observations of the patients when in reality it was Witness 12. Accordingly, this charge is found proved.

Charge 27a

a. On 27 May 2019, failed to provide adequate care to a patient, in that you;
Took two hours to administer a prescribed medication.

This charge is found NOT proved.

The panel considered that the evidence relating to this charge was only hearsay. The evidence was that it was a very busy night. In her written statement, Witness 11 stated, *'During the night shift on 27 May 2019, the Nurse in Charge received a complaint from a medical doctor concerning administration of intravenous ("IV") antibiotics that were prescribed for Nurse Adjo's patient. The antibiotics were allegedly prescribed for 04:00 but were not given until 06:00. I cannot comment further as I was unable to proceed with an in house investigation as the Nurse in Charge did not have any details of the doctor making the complaint, or the patient details, or medication.'*

You denied this charge. In your written submissions you stated that *'I remember this incident and the patient whose partner called to say they were in pain. It was in A&E which is very fast paced I went to inform the Dr of patient complain of pain, It was then doctor, said they had just been given patient painkillers.'*

The panel determined that there was no direct evidence relating to this charge and as has been stated by Witness 11 that no in-house investigation took place as they did not have the details of the doctor who complained, the identity of the patient in this case and the medications involved. Accordingly, this charge is found not proved.

Charge 27b

b. Failed to introduce yourself.

This charge is found proved.

The panel was of the view that there was an expectation from within the nursing profession that you should have introduced yourself when treating a patient. The panel has seen hearsay evidence of two nurses and a doctor and that a patient had made a complaint that you had not introduced yourself. The panel took into account the hearsay on the basis that there are a number of emails from two nurses and a doctor stating that you failed to introduce yourself to the patient who reported that they saw you treating a patient on 27 May 2019.

The panel considered the written statement of Witness 11 who stated, '*On 5 June 2019, I received an email from Dr Ando, which provided further detail about the patient complaint. I attach a copy of Dr Ando's email as Exhibit "SF17". As detailed in the letter, the patient was concerned that Nurse Adjo did not introduce themselves, did not seem to know anything about the patient, did not explain anything they were doing and told them they would give pain relief to the patient after the patient had just had pain relief.'*

The panel determined that the weight of the hearsay is elevated in weight because a number of professionals which included a doctor informed your manager about this complaint.

The panel also took into account your evidence. In your written submissions you stated that *'I found out that all these was witch hunt to affirm what [Witness 1] started in the community.'*

Accordingly, this charge is found proved.

Charge 27c

c. Did not assess the patient sufficiently.

This charge is found NOT proved.

The panel was unclear on what was required in assessing this particular patient sufficiently. In these circumstances there is little specific evidence to show you have failed to assess this patient sufficiently. Accordingly, this charge is found not proved.

Charge 27d

d. Offered the patient pain relief shortly after they had received pain relief;

This charge is found proved.

The panel noted that a doctor and two nurses witnessed you offer a patient pain relief shortly after they had received pain relief medication. The sister in the A&E stated *'I spoke with Ethel and she informed me that it had been a miscommunication and she had thought the medication was due when it had already been given.*'

The panel was satisfied that there was indeed a misunderstanding which resulted in you offering a patient pain relief when you believed it had not been received, whereas in fact it had previously been received shortly before. Accordingly, this charge is found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your

fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct and impairment

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

Mr Rye identified the specific and relevant standards where the NMC contends your actions amounted to misconduct. He referred to the following comments of Lord Clyde in *Roylance v General Medical Council* [1999] UKPC 16 in relation to the definition of misconduct:

> '*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a* [nurse] *practitioner in the particular circumstances*'.

Mr Rye invited the panel to consider the following provisions of the Code as being relevant in this case: provisions 1, 2, 4, 6, 7, 8, 13, 19, 20 and 22.

Mr Rye submitted that a number of charges that are found proved relate to your clinical failures which exposed patients to potential risk of harm and there are some that relate to attitudinal issues, including dishonesty that call into question your professionalism and integrity. He submitted that the concerns relating to clinical issues may be remediated but the attitudinal issues are more difficult to address which would need evidence for the panel to be convinced that they have been addressed. He stated that you would need to demonstrate remediation through remorse, insight, and the steps you have taken to strengthen your practice. However, there is no evidence before the panel to show that the facts found proved are addressed and therefore a finding of impairment is necessary.

Mr Rye 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Rye submitted that impairment needs to be considered as at today's date, i.e. whether your fitness to practise is currently impaired. The NMC defines impairment as a registrant's suitability to remain on the register without restriction.

Mr Rye submitted that the questions outlined by Dame Janet Smith in the fifth Shipman Report are instructive. Those questions were:

a. *'has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
b. *has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*

c. *has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*
d. *has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

Mr Rye submitted that all four of the limbs apply in this case. He said you acted unprofessionally and dishonestly. He submitted that in the absence of any evidence of remediation, remorse, insight and steps taken to strengthen your practice, it is clear that you pose a risk to the public and that there is a need to maintain public confidence through a finding of impairment.

After the position had been explained to you by the legal assessor that you cannot reopen the facts of the case, you spent some time going through some of the more serious charges and explained that you understood what was wrong about what you are said to have done, and that you would not do these things again.

You stated that you understand the importance of what is alleged against you and that it was important for you not to commit these things in the future. You gave assurance in relation to the facts found proved that you will not repeat those failures and be mindful of your behaviour and attitude towards patients, their relatives and your colleagues.

You told the panel that you have been working since you left the Trust and there have been no concerns raised against you. Therefore, your fitness to practise is not currently impaired. You directed the panel to a positive reference dated 13 October 2022 from a senior sister with whom you worked. The reference states:

'I have worked with Ethel for a number of years when she has worked bank shifts with us in the Emergency Department at Northwick park hospital. I have also had experience of Ethel when she has been in the surgical assessment unit at Northwick park. From what I have witnessed in the surgical unit she is polite, respectful and caring towards patients. She is a great advocate for patient care and I have witnessed her challenge a prescription with a doctor that was incorrect. Ethel frequently works on trolley's here in the ED and as a senior sister in the department I have not received or been aware of any complaints of her

work from colleagues, patients or family members. She is an organised and reliable member of the team when she is working with us. She is quick to escalate any concerns in regards to her patients and what care needs to be carried out. When she attends the ED to work she is punctual, appropriately dressed and well mannered. I have no concerns in regards to her clinical care that I have witnessed first hand.'

The panel accepted the advice of the legal assessor which included reference to *Grant.* He said that a breach of duty must be serious if it is to amount to misconduct.

Decision and reasons on misconduct

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

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

'Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

Communicate clearly

To achieve this, you must:

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

Recognise and work within the limits of your competence

To achieve this, you must:

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

13.5 complete the necessary training before carrying out a new role

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

Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

Fulfil all registration requirements

To achieve this, you must:

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. When considering the misconduct, the panel considered each charges individually and determined that your actions in the following charges did not amount to misconduct because in each case the panel judged that they did not constitute a serious breach of duty: 1, 4b, 4c, 6, 8c, 14, 16b, 16c, 17, 18, 21a, 21b, 22, 23, 24, 27b and 27d.

The following charges amounted to misconduct because in each case the panel judged they constituted a serious breach of duty: 3a, 8d, 9a, 9b, 9c, 10a, 10b, 10c, 10d, 10e, 11a, 11b, 11c, 12a, 16a, 25a, 25b, 26. The panel found that the charges were serious departures from the standard practice and there were numerous breaches of the Code relating to behaviour, actions, professionalism and honesty. The most significant misconduct arises in charges 25 and 26; your failure to carry out observations and your dishonest statement to a senior sister that you had carried out observations when you had not.

The panel found that your clinical failures and the attitudinal issues represented by the charges, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. At 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.'*

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

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

The panel determined that limbs a, b, c and d were engaged in this case. It also determined that your misconduct is a serious breach of both trust and the fundamental tenets of the nursing profession and, further, brings the profession into disrepute.

There was no evidence of actual harm to patients. However, it concluded that your actions had the potential to cause harm to patients such as lack of patient observation, attention to infection control, clinical practice in care in so far as administration of heparin/fragmin.

The panel considered that certain types of misconduct, including attitudinal issues and dishonesty are difficult to address. The panel was of the view that there is a risk of

repetition because you have very limited insight into your misconduct and do not seem to accept responsibility for your failings. There is no or little evidence that you have taken any steps towards strengthening your practice or addressing your shortcomings. The panel found your practice presents a risk to the public and could bring the profession into disrepute, and that you have breached the fundamental professional principles.

The panel accepted your point in that you had been practising for over 20 years. The panel considered that despite the extra challenges in the role which resulted in these proceedings, you should have been able to conduct yourself professionally. The findings against you are such that the panel does not accept you acted professionally all of the time as you suggested. The most significant aspect of your misconduct was that you, were dishonest in relation to your failure to carry out observations on a patient, which involved your lying about was written on an observation chart.

Furthermore, the panel was not satisfied that the concerns highlighted will not recur if you were faced in a similar situation in a working environment in which you were not comfortable. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel determined that a finding of impairment on public interest grounds is required because public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel therefore also found your fitness to practise impaired on the grounds of public interest.

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 five months. The effect of this order is that the NMC register will show that your registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard generally to the Sanctions Guidance (SG) and specifically to the Guidance relating to dishonesty at SAN 2, both published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Rye informed the panel that in the Notice of Hearing the NMC advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired.

Mr Rye submitted that the NMC is seeking a striking-off order because your misconduct fell so seriously below the standard expected of a registered nurse that it is fundamentally incompatible with you remaining on the Register. He submitted that as your behaviour is not at the lower end of the spectrum of misconduct, it would not be appropriate for no further action to be taken or for a caution to be applied. He submitted that this is misconduct which needs to be marked. He also submitted that as the issues involved do not only concern your clinical practice but involve attitudinal issues as well, that no practical or workable conditions could be applied and so a conditions of practice order is not appropriate either.

Mr Rye highlighted the aggravating and mitigating features. The aggravating features are as follows:

- Your misconduct was wide-ranging
- Not a single instance of misconduct.
- You are an experienced nurse
- You have breached your duty of candour
- You lacked integrity
- There is dishonesty linked to your misconduct
- You have demonstrated a lack of professionalism and trust
- You have sought to blame others for your misconduct
- You have shown deep-seated attitudinal issues

The mitigating features are as follows:

- You have had a long standing career
- There was no actual harm to patients
- You have recently engaged with the process
- There is no evidence of the concerns being repeated
- The dishonesty is a one off incident.

Mr Rye submitted that a suspension order would not satisfy the wider public interest given the serious nature of the misconduct concerned. Mr Rye said that your behaviour was serious, continued over months and demonstrated a lack of professionalism which could affect public confidence in the profession and in the NMC if you remain on the register.

You told the panel that you have never harmed any patients and that you would never do such a thing. You have cared for your patients for the last 23 years and all you did was help the sick and the needy. You have never lied about anything in relation to your practice and said that you can reassure the panel that you will never do anything to put your patients in danger. You said that your family, friends, community and colleagues know that you are a kind and compassionate person who always wants the best for her patients.

You stated that you have given your best to the community and the best part of your life to the people of UK, and England. You have done your best and will continue to do so in the future for your patients. You stated that if the panel decides to strike you off the NMC register, you will accept your fate. You said that you are a pleasant and helpful women who had not repeated those mistakes and will not do so ever again.

Upon questioning from the panel, you stated that you have been working at Northwick Park Hospital, in the A&E department since 2018 but have retired in June 2023. You currently do only bank shifts, two or three nights a week. You told the panel that your source of income is nursing including a nursing pension, and that if you are suspended

or struck off it will have a detrimental financial impact on you and your family. You said that you support family members and that it would be difficult for you to finance a return to nursing course at the end of the five year strike off period.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- You have developed limited insight into your misconduct
- You conduct could have put patients at risk of harm
- There are a wide range of concerns from November 2018 to May 2019
- You have demonstrated deep-seated attitudinal issues
- Your misconduct involved dishonesty

The panel also took into account the following mitigating features:

- No actual harm was caused to patients
- There have been no other concerns raised against you since 2019
- There has been no previous history of misconduct

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.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case and the public interest issues identified, such an order

would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. As a result of your further evidence, it became clear that when you had previously said you had retired in the previous year, that related only to your retirement from a fulltime employment with the Trust. You have been working at Northwick Park Hospital and have been working for roughly two or three shifts per week, generally at night. It is accepted by the NMC that there is no misconduct during the course of your career outside the period of six months, which is the basis for the panel's findings of misconduct. Consequently, it appears that you have been able to work for a period of nearly five years without any evidence that you present a risk to the public. The panel is not persuaded that there is no risk, given its findings of

misconduct during this six months period. However, it would be unrealistic and unfair not to take this period of work into account in assessing the risk that you might represent. No application appears to have been made for an interim order by the NMC during the intervening period.

The panel considered that it would not be necessary to impose a suspension on public protection grounds. However, the seriousness of the misconduct and in particular the matter set out in charges 25 and 26, relating to observations and dishonesty, have satisfied the panel that it is necessary to make a suspension order on public interest grounds. The period of this suspension order will be five months. This, in the panel's judgment, will be sufficient to mark the seriousness of the misconduct, but not to terminate your career as a nurse.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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. Any suspension order is likely to have a significant financial effect on you and those whom you support. However, the necessity of upholding proper standards of the profession require such an order in the view of the panel.

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 five months was appropriate in this case to mark the seriousness of the misconduct.

Before 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:

- You providing a detailed reflective piece to the panel before the next review, to demonstrate how you have improved your insight and your practice since June 2019
- Any training certificates relating to nursing since June 2019
- You providing references/testimonials from your employers/supervisors both as a nurse and if appropriate any other employment. You may be assisted by referring to the NMC guidance relating to references/testimonials (FTP-13b)
- Your attendance at the next review hearing

This decision will be confirmed to you in writing.

Interim order

As the substantive 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 is in your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Rye. He submitted that an interim suspension order for the period of 18 months is necessary to cover the period of

any potential appeal. He said that this order would fall away after 28 days if no appeal of the substantive suspension order is made. He asked for that order on the grounds of public protection and the public interest.

You made no submissions in relation to an interim order.

The panel accepted the advice of the legal assessor. He drew the panel's attention to the facts that they had found impairment on both public protection and public interest grounds, but that the substantive suspension order had been made only on public interest grounds. He advised that no interim should be made unless it was justified on either public protection grounds or public interest grounds and the test was necessity. It was not enough that the order would be desirable. If an order was required, interim condition of practice should be considered first.

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 be necessary for public protection, and interim suspension order would not be required for public protection. However, it was necessary in the public interest that there should be an interim suspension order to take effect immediately. This is necessary to maintain public confidence in the regulatory process. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 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.