Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 5 February 2024 – Monday, 12 February 2024

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

Name of Registrant:	**Eruore Augustina Obibi**
NMC PIN:	94I0385E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing (Level 1) – 23 March 1998
Relevant Location:	Belfast
Type of case:	Misconduct
Panel members:	Michelle McBreeze (Chair, Lay member) Mark Gibson (Registrant member) Laura Wallbank (Registrant member)
Legal Assessor:	Graeme Sampson (Monday, 5 February 2024 – Thursday 8 February 2024) Simon Walsh (Friday, 9 February 2024) Graeme Sampson (Monday, 12 February 2024)
Hearings Coordinator:	Opeyemi Lawal
Nursing and Midwifery Council:	Represented by Hena Patel, Case Presenter
Ms Obibi:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 4a, 4b, 4c and 5
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Suspension order (9 months with review)**

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 Ms Obibi was not in attendance and that the Notice of Hearing letter had been sent to Ms Obibi's registered address by recorded delivery and by first class post on 4 January 2024.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Ms Obibi's registered address on 5 January 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and venue of the hearing, and amongst other things, information about Ms Obibi'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 Ms Obibi has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Obibi

The panel next considered whether it should proceed in the absence of Ms Obibi. It had regard to Rule 21 and heard the submissions of Ms Patel who invited the panel to continue in the absence of Ms Obibi. She submitted that Ms Obibi had voluntarily absented herself.

Ms Patel referred the panel to the telephone note dated 4 January 2024 which included notes from a telephone call between Ms Obibi and her NMC case officer, in which she stated that she will not be present at the hearing and is content for the hearing to proceed in her absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William).*

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

- No application for an adjournment has been made by Ms Obibi;
- Ms Obibi has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses are due to attend today to give live evidence;
- The charges relate to events that occurred in 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Obibi in proceeding in her absence but the panel was of the view that they could mitigate this by asking the witnesses to comment on Ms Obibi's view, presented in her reflective document put before the panel.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Patel under Rule 31 to allow the hearsay testimony of Patient A into evidence, in relation to charge 3. Despite numerous attempts, the NMC had not been able to obtain a signed, written statement from Patient A. However, the NMC received a response from Patient A's key worker, in which they told the NMC that any level of contact with Patient A was inappropriate as Patient A is a vulnerable person. Ms Patel submitted that the evidence is highly relevant and though not provided during the course of the NMC's investigation, was produced for the purpose of the internal investigations.

Ms Patel submitted that Patient A's account should be admitted into evidence, as the panel can test it with the evidence provided by the witnesses.

Ms Patel submitted that the hearsay evidence is not the sole and decisive evidence for the charge and in paragraph 8 of Ms 4's witness statement supports Patient A's account. Ms Patel further submitted that there will be no unfairness to Ms Obibi if the evidence is admitted.

The panel heard and accepted the legal assessor's advice in respect of this application.

The panel considered whether Ms Obibi would be disadvantaged by the change in the NMC's position of allowing hearsay testimony into evidence. The panel determined that

Ms Obibi would not be disadvantaged by admitting the evidence, as it is not the sole and decisive evidence on this charge.

The panel determined to admit the hearsay evidence on the basis that it can be tested with Ms 4.

In these circumstances, the panel came to the view that it would be fair and relevant to admit into evidence the hearsay evidence of Patient A but would give what it deemed was the appropriate weight once the panel had heard and considered all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Patel, on behalf of the NMC, to amend the wording of charge 3.

The proposed amendment was to amend the date. It was submitted by Ms Patel that the proposed amendment would more accurately reflect the evidence provided by the witnesses.

> "That you, a registered nurse:
>
> 3. On ~~2 May 2022~~ **a date between 28 April and 2 May 2022**, you failed to preserve patient safety in that you left keys to the Unit unattended;
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

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

The panel was of the view that such an amendment, as applied for, provided clarity, was in the interest of justice and would not alter the nature of the charge. The panel was satisfied that there would be no prejudice to Ms Obibi and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge

That you, a registered nurse:

1) On 20 March 2022, failed to preserve patient safety in that you left the door to the Unit unlocked;
2) On 28 April 2022, failed to provide care in accordance with Patient A's care plan and/or risk assessment in that you failed to undertake adequately, or at all, 1:1 observation for Patient A;
3) On a date between 28 April and 2 May 2022, you failed to preserve patient safety in that you left keys to the Unit unattended;
4) On 5 May 2022 you behaved inappropriately towards Patient A in that you:
    a. put your bottom towards Patient A and/or slapped your bottom and said "slap it, slap my arse" or words to that effect;
    b. said "kiss my arse" or words to that effect;
    c. put your index and middle finger up to the ceiling and said "fucked in the arse" or words to that effect
5) Your actions at charge 4(a) and/or 4(b) and/or 4(c) breached professional boundaries

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

Background

Ms Obibi was referred to the NMC on 7 June 2022 by the Clinical Director at the Agency she was employed at. At the time of the concerns raised in the referral, Ms Obibi was employed by the Agency as a Mental Health nurse and had been placed on a Child and Adolescent Mental Health Unit (CAMHS) called Beechcroft Unit at Belfast Health and Social Care Trust.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Obibi.

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

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

- Ms 1: Ward Sister of the Psychiatric Intensive Care Unit
- Ms 2: Staff Nurse on Beechcroft Unit, a Child and Adolescent Mental Health Service (CAMHS)
- Ms 3: Student Mental Health Nurse

- Ms 4: Health Care Worker on Beechcroft Unit
- Ms 5: Band 5 Staff Nurse on Beechcroft Unit
- Mr 1: Deputy Charge Nurse on Beechcroft Unit
- Mr 2: Health Care Worker on Beechcroft Unit

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

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

Charge 1

> "On 20 March 2022, failed to preserve patient safety in that you left the door to the Unit unlocked".

This charge is found proved.

In reaching this decision, the panel took into account Mr 1, Mr 2 and Ms 1's NMC witness statements and oral evidence, the Operational Policy for Beechcroft Inpatient Unit and Ms Obibi's reflective statement.

In Mr 1's NMC witness statement, he stated;

‘We found the door was unlocked. I delegated to the member of staff I was with to walk the young person back into the Ward and I locked the door and went to see who had left it open.’

In Mr 2’s NMC witness statement, he stated:

‘I did not leave the Ward with Tina she may have been close behind me but we did not leave the Ward at the same time. I was not aware of anyone being behind me but I remember I locked the door.’

The panel was of the view that Mr 2’s oral evidence was consistent with his NMC witness statement.

In Ms 1’s NMC witness statement, she stated:

‘Again I was informed of this incident after it happened, it was reported to me that Tina had left a door unlocked on 20 March 2022. The relevant parts of this policy are 4.2 Security Guidelines; “Access to ward areas are restricted and the doors to each ward are locked. As a service, the doors of each ward are kept locked for the safety of the young people, and to protect and prevent unwanted visits or from people who may attempt to bring dangerous or illegal items onto the ward, which may make the ward less safe for young people, staff and visitors. Each ward has an intercom fitted to ensure staff are alerted to any visitors who require entry to the ward. In Beechcroft, we can have both voluntary and detained admissions. We want to make sure that all practical steps are taken to ensure that all the patients are aware of their right to leave the ward with staff or family for walks in the grounds or on home pass. These arrangements will be agreed and documented in your care plan.’

During Ms 1’s oral evidence, she explained to the panel that as a regular agency employee, Ms Obibi had her own keys.

In Ms Obibi's reflective statement she stated:

> *'As I got to the entrance door. I met Mr 1 the senior nurse who said you left the door unlocked. I was surprised, I told him in the present of the carer that, the carer opened the door for me to go out and he remain inside in between the two doors waiting to carry out search. I never knew the carer did not lock the door while waiting in between the doors and while I outside trying to get the patient to return to the ward.*
> *…*
> *I never opened the doors while going out of the unit, I went first and a career was waiting in between the entrance doors and the ward door He has the key and knew that he did not lock the doors.[sic]'*

During Mr 2's oral evidence he explained that this did not happen.

The panel considered the conflicting accounts between Ms Obibi's recollection of events and her colleagues. However, the panel determined that Ms Obibi's account is deflective and seeks to blame others, which in turn makes her evidence less reliable. Further, the panel bore in mind the similarity of the accounts given by Mr 1 and Mr 2.

Therefore, in considering all of the evidence before it, the panel determined that it was more likely than not that Ms Obibi left the door unlocked and found this charge proved.

Charge 2)

> "On 28 April 2022, failed to provide care in accordance with Patient A's care plan and/or risk assessment in that you failed to undertake adequately, or at all, 1:1 observation for Patient A".

This charge is found proved.

In reaching this decision, the panel took into account Ms 2's and Ms 4's NMC witness statements and their oral evidence alongside Patient A's care plan. The panel also took into account Ms Obibi's reflective statement.

In Ms 4's NMC witness statement she stated:

> *'Patient A then came out of her bedroom to the hub area, I was then put on Patient A's 1:1 observations. This is when Patient A said to me that she had urges to tie a ligature when she was in the shower and she said that Tina had not observed her. She said Tina was not in the bathroom at all. Patient A said she had a shower and got dressed in the bathroom because she did not want to get dressed in the bedroom whilst the door was open. Tina had stayed sitting in the corridor on a chair.'*

During Ms 4's oral evidence she explained that Ms Obibi would have been aware of Patient A's level of risk and care plans, via Patient A's notes and handover. Ms 4 also explained the layout of the bedroom and told the panel that you could not see into the shower from the corridor, as it was to the right of the bedroom door. She explained that she observed Ms Obibi sitting in the corridor facing the bedroom.

In Ms Obibi's reflective statement she stated:

> *'I was allocated to provide a clinical observation of one to one with no privacy to a young person (patient) The young person (Patient) requested to have a shower which all toiletries were provided. While the young person was in the shower, I lowered the door cover to the shower room so that I could see her. We were both in conversation while she was in shower.'*

During Ms 2's oral evidence she explained that the door cover can only be lowered to shoulder level and that you cannot see what the patient is doing with their hands.

The panel was of the view that Ms Obibi's overview of the incident does not suggest that she has any proper regard to the level of risk Patient A presented to herself.

The panel accepted the evidence that the nursing team made a decision that Patient A required 1:1 observations without privacy until the post admission review by the Doctor which continued these observations overnight.

The panel accepted the evidence of Ms 2 and Ms 4 and determined that given Ms Obibi's position in the corridor she could not have undertaken 1:1 observations without privacy.

The panel therefore found this charge proved.

Charge 3)

> "On a date between 28 April and 2 May 2022, you failed to preserve patient safety in that you left keys to the Unit unattended".

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's and Ms 4's NMC witness statements and oral evidence, the Operational Policy for Beechcroft Inpatient Unit and Ms Obibi's reflective statement.

In Ms 4's NMC witness statement she stated:

> *'On 05 May 2022 I completed a Nurse Bank/Agency Staff Performance form in relation to a concern where Tina had left her keys unattended. We were all in the hub area, the children and some staff. I was doing observations of a patient. Tina had left her keys on the coffee table. I had not realised until Tina had come back, she'd gone to the kitchen to get a drink. I heard Tina asking "where are my keys?" I*

think she might have thought one of the patients took them. I think it was Patient A who said I saw them on the table, and I looked and saw the keys on the table. Tina then picked these up.'

The Operational Policy for Beechcroft Inpatient Unit stated:

> *'Being entrusted with swipe card and keys for Beechcroft places the responsibility of the staff member to keep them safe and use them correctly.*
>
> *All staff will be allocated a swipe card for access to the main wards, staff area, main reception and admin areas of the building, a key for access to offices/rooms, a fire key and a locker key. The Charge Nurse/Ward Sister will allocate these keys which will be signed for by the member of staff.*
>
> *Non-permanent staff will be allocated a set of keys at the start of shift by the nurse in charge which will be signed out and in by the member of staff and the nurse in charge.*
>
> *The Charge Nurse/Ward Sister will securely keep any supplementary keys/swipe cards.*
>
> *Each member of staff is responsible for the security of the building ensuring that doors are closed, each room being left safe and secure after each use, being mindful of a safe environment for all.'*

During Ms 1's oral evidence she explained that Ms Obibi was considered as a permanent staff because she regularly worked on the unit for the agency.

In Ms Obibi's reflective statement she stated:

'…I accepted, got up from the seat and my key fell out of my pocket on the chair where is was seating in the hub area. I immediately took the key and put it back into my pocket…'

The panel were of the view that Ms 4's written and oral evidence was consistent with the record of events on the Nurse Bank/Agency Staff Performance Form, written at the time of the incident. The panel was of the view that Ms Obibi's reflective statement had a tone of seeking to blame others and therefore preferred Ms 4's version of events. The panel determined that Ms Obibi had worked on the unit for long enough to understand her responsibilities regarding her keys, as per the policy.

The panel determined that it is more likely than not that Ms Obibi left her keys unattended and therefore found this charge proved.

Charge 4)

"On 5 May 2022 you behaved inappropriately towards Patient A in that you:

a) put your bottom towards Patient A and/or slapped your bottom and said "slap it, slap my arse" or words to that effect
b) said "kiss my arse" or words to that effect
c) put your index and middle finger up to the ceiling and said "fucked in the arse" or words to that effect".

This charge is found proved.

In reaching this decision, the panel took into account Ms 2's and Ms 3's NMC witness statements and oral evidence. The panel also took into account Ms Obibi's reflective statement.

In Ms 2's NMC witness statement she stated:

‘In response to this Tina said that she did not know what this meant and did not know some of the gestures used over here. We were joking about asking Tina how could she not know that gesture. Tina then said something along the lines of “do you know this one? kiss my arse.” Everyone was a bit shocked, thinking why did she say that. The two patients started laughing. Tina then got up off her chair walked over to Patient A, who was sitting in-front of me on the floor, bent over in front of Patient A putting her bottom in Patient A’s face and was in her personal space. Tina then said “slap it, slap my arse” and then she slapped her own bottom in Patient A’s face.

I asked Tina why she had done that and explained she shouldn’t be doing that. Tina just continued to laugh and Patient A said something like “no I’m not slapping your arse fuck off”. I felt that Tina had escalated the situation. The other patient in the room looked very shocked.’

In Ms 3’s NMC witness statement she stated:

‘I saw Tina smack her bum directed towards Patient A and I remember hearing an inappropriate response from Tina to Patient A but I cannot recall exactly what was said. I can’t recall how close Tina was to Patient A.’

The panel noted that Ms 2’s and Ms 3’s oral evidence shows that they both had clear recollections of the events and is consistent with their witness statements, and with the events documented on the Nurse Bank/Agency Staff Performance Form relating to this incident.

In Ms Obibi’s reflective statement she stated:

‘After the communication between [Ms 2] and the [Patient A] started to stick her middle finger and use the first and second finger again then saying, Tina you are a

poo and fuck you. The [Ms 2] then started to laugh at what [Patient A] was saying to me.

…

I never used any offensive words of kiss my arse" and made inappropriate gestures towards [Patient A]. On the same day in May 2022, the senior Nurse in charge [Ms 2] who has the same name with [Ms 2] that was laughing at what [Patient A] verbal abuse towards me.'

During Ms 2's oral evidence, she stated that she did not encourage Patient A's behaviour towards Ms Obibi and Ms 3 also stated during her oral evidence that she did not recall Ms 2 encouraging Patient A or laughing. However, they both explained that Patient A was known to have a tendency to this type of behaviour.

The panel were of the view that Ms Obibi was aware that Patient A displayed sexually disorientated conversation and behaviour, therefore, Ms Obibi's responses should have been more considered and professional.

The panel noted that the oral evidence provided by Ms 2 and Ms 3 remained consistent in all of their accounts of the incident and reinforced the degree of shock that they felt in observing Ms Obibi's actions.

The panel determined that it is more likely than not the accounts of Ms 2 and Ms 3 are an accurate account of the incident and on the balance of probabilities these incidents did occur as described in charge 4.

Therefore panel found this charge proved.

Charge 5)

"Your actions at charge 4(a) and/or 4(b) and/or 4(c) breached professional boundaries."

This charge is found proved.

In reaching this decision, the panel exercised its own independent judgement.

The panel also took into account the NMC Code, in particular:

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

- Code 20.6
  'stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.'

The panel considered that a registered nurse is expected to act in a professional way at all times and be aware how their behaviour affects the level of trust that colleagues and patients have in them and in the profession. The panel determined that Ms Obibi's actions caused a level of shock from both colleagues and patients who witnessed the behaviour. The panel considered that regardless of Ms Obibi's intention, her behaviour breached professional boundaries.

Therefore, the panel found this charge proved.

Fitness to practise

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

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

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

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

Submissions on misconduct

In her submissions, Ms Patel referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Patel invited the panel to take the view that the facts found proved amount to misconduct.

Ms Patel identified the specific, relevant standards where Ms Obibi's actions amounted to misconduct, in particular Code 20, 20.6 and 20.8.

Ms Patel submitted that Patient A was admitted to Beechcroft Ward under 'serious circumstances', which were noted in her care plan and even though the exact wording of that care plan may not have been available to Ms Obibi, it was clear that Patient A was a

high risk patient. She further submitted that despite Ms Obibi knowing this, she did not conduct her searches and her observations adequately and consequently put Patient A at severe risk of harm.

Ms Patel submitted that the digressions that have occurred were not minor digressions. Ms Patel further submitted that Ms Obibi's actions could have had devastating consequences to the patients in her care, and therefore her actions fell seriously below the standard that is required of a registered nurse and amount to misconduct.

Ms Patel invited the panel to find Ms Obibi's actions amount to misconduct.

Submissions on impairment

Ms Patel moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Patel submitted that Ms Obibi had exposed the patients in her care to an unwarranted risk of harm and acted in a way that would have brought the nursing profession into disrepute. Ms Patel further submitted that Ms Obibi had breached fundamental tenets of the nursing profession.

Ms Patel submitted that Ms Obibi essentially failed to promote professionalism and preserve patient safety. Ms Patel further submitted that Ms Obibi's actions breached the first three strands of the Dame Janet Smith test. Ms Patel submitted that while Ms Obibi's actions are capable of remediation, there is no evidence of insight or accountability or understanding of the impact her actions could have had on the patients, her colleagues, nursing profession, or even the wider public.

Ms Patel submitted that Ms Obibi's reflections either amount to a complete denial of not doing anything wrong or amount to blaming others and victimise herself, whilst underplaying the impact of her actions.

Ms Patel invited the panel to find Ms Obibi's practice currently impaired.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to The terms of The Code Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015.

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

> *'**3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.*
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice.***
> *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.*
>
> ***20 Uphold the reputation of your profession at all times***

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people.
20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges individually and as a collective amount to misconduct.

The panel determined that Ms Obibi breached professional boundaries, which amounts to serious misconduct.

The panel noted that Ms Obibi had prior knowledge of Patient A's fluctuating risk and determined that her actions and failure to follow the Trusts Operational policy and Patient A's care plans put both Patient A and other patients at Beechcroft at risk of harm.

The panel found that Ms Obibi's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Obibi's 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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

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

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

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

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

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

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

d) *…'*

The panel finds that patients were put at risk as a result of Ms Obibi's serious misconduct which breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that within Ms Obibi's reflective statement she failed to demonstrate an understanding of how her actions put the patients at a risk of harm or demonstrated an understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. The panel determined that Ms Obibi continuously apportioned blame to colleagues and lacked insight into her actions and the risks that patients were exposed too. Further, there was no evidence in Ms Obibi's reflective pieces of any remorse for her actions.

The panel noted that it had no evidence of Ms Obibi strengthening her practice before it, namely evidence of training specific to professional boundaries, managing risk and safety and security in a clinical setting such as Beechcroft. Further, the panel did not have any testimonials from employers or work colleagues, in any setting, clinical or otherwise.

The panel is of the view that there is a high risk of repetition based on the contents of Ms Obibi's reflective statement, the ongoing lack of insight and deflection and the absence of

any evidence that Ms Obibi has strengthened her practice. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because the seriousness of Ms Obibi's actions and the potential consequences that could have occurred. The panel determined that a reasonably informed member of the public would be shocked by the charges found proved. Therefore, the public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel also finds Ms Obibi's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Obibi's 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 9 months with a review. The effect of this order is that the NMC register will show that Ms Obibi's 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 to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Patel submitted that the NMC's proposed sanction bid was a suspension order for a period of 3 months.

Ms Patel outlined the aggravating and mitigating features.

Ms Patel submitted that taking no further action would be inappropriate given that all the charges were found proved and there was a risk of repetition and for the same reasons a caution order would not be appropriate.

Ms Patel submitted that a conditions of practise order would not be appropriate to address the concerns regarding public protection and public interest, in particular maintaining public confidence in the nursing and midwifery professions.

Ms Patel further submitted that this case raises concerns about Ms Obibi's attitude and her behaviour towards patients and colleagues, and at this stage there are no workable, relevant, measurable or proportionate conditions that can address the risks that have been identified.

Ms Patel submitted that a suspension order is the appropriate sanction in this case, as Ms Obibi's actions put the patient's safety at risk of harm by behaving inappropriately and not having any regard to the Trusts Operational policy.

Ms Patel further submitted that Ms Obibi has a general defensive and deflective attitude and would justify a suspension order of three months as the appropriate sanction.

Decision and reasons on sanction

Having found Ms Obibi's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not

intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Ms Obibi's conduct put patients at risk of harm
- There is no evidence of strengthening practice
- Lack of insight into her failings and has not addressed how she would act differently in the future
- Lack of insight into the risks posed to the patients given the type of environment she was working in and the vulnerable patients in her care
- Did not appreciate the concerns around patient safety and safeguarding
- Failing to adhere to the Trust Operational policy
- Some attitudinal issues – defensive and deflective

The panel also took into account the following mitigating features:

- No actual harm was caused to patients
- Some very limited insight

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 protection issues identified, an order that does not restrict Ms Obibi's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Obibi's

misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Obibi's 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;*

The panel took into account that Ms Obibi has not provided any evidence to suggest that she has a willingness to address the issues or retrain. However, the panel is aware that Ms Obibi has recently stated that she does not want to be a nurse and would like to focus on personal aspect of her life. The panel concluded that Ms Obibi has no intention of returning to nursing and she has not demonstrated any insight into improving her nursing practice. Further, Ms Obibi has only demonstrated limited engagement with the NMC.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and for the above reasons.

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

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

- *No evidence of repetition of behaviour since the incident.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel determined that a suspension order is appropriate in this circumstance as it will give Ms Obibi the time to reflect on the issues raised, her career moving forward and undertake continuing professional development/ training. The panel were of the view that Ms Obibi's reflective statement was unsatisfactory and attempts to minimise her failings, deflects blame on others and demonstrates a lack of regard to the risks posed to the vulnerable patients in her care.

The panel went on to consider whether a striking-off order would be appropriate but, taking account of all the information before it, 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 Ms Obibi's 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 Ms Obibi. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 9 months with review, was appropriate in this case to mark the seriousness of the misconduct and allow Ms Obibi time to reflect and undertake training in the areas identified.

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

Any future panel reviewing this case would be assisted by:

- Attendance at future hearings and engagement with the process
- Information regarding Ms Obibi's intentions about her nursing career
- Information about the type of work Ms Obibi has undertaken during her suspension
- Evidence of training courses completed
- Testimonials from current employer
- Reflective piece addressing the issues the panel have identified

This will be confirmed to Ms Obibi in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Obibi's 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 Ms Patel. She submitted that an interim suspension for 18 months is appropriate to cover the appeal period, on the grounds of public protection and public interest.

Decision and reasons on interim order

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

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

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

That concludes this determination.