Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
6 – 14 April 2021

Nursing and Midwifery Council
Virtual Hearing

Name of registrant:	**Cordelia C Ihejieto**
NMC PIN:	02F0242O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – June 2002
Area of registered address:	Bristol
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair, Lay member) Jonathan Coombes (Registrant member) Chris Thornton (Lay member)
Legal Assessor:	Gillian Hawken
Panel Secretary:	Xenia Menzl
Nursing and Midwifery Council:	Represented by Stephen Earnshaw, Case Presenter
Mrs Ihejieto:	Not present and not represented in absence
Facts found proved by admission:	Charges 5 (a), 5 (b), 5 (c), 5 (d), 5 (e), 6 and 7
Facts found proved:	Charges 1, 2, 4 (a), 4 (b), 8, 9, 10, and 11
Facts not proved:	Charge 3
Fitness to practise:	**Impaired**
Sanction:	**Striking-Off Order**
Interim order:	**Interim Suspension Order, 18 Months**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Ihejieto was not in attendance and that the Notice of Hearing letter had been sent to Mrs Ihejieto's registered address by recorded delivery and by first class post on 2 March 2021.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Ihejieto's registered address on 3 March 2021. It was signed for against the printed name of '*CORDELA*'.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates of the hearing and the fact that this would be a virtual hearing. Amongst other things, it also contained information about Mrs Ihejieto's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Earnshaw, 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.

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

The panel next considered whether it should proceed in the absence of Mrs Ihejieto. It had regard to Rule 21 and heard the submissions of Mr Earnshaw who invited the panel to continue in the absence of Mrs Ihejieto. He submitted that Mrs Ihejieto had voluntarily absented herself.

Mr Earnshaw referred the panel to communication between the NMC and Mrs Ihejieto which included a telephone note by the NMC Case Officer, dated 16 February 2021, stating:

> '*I asked* [Mrs Ihejieto] *about attending the hearing and she informed me that she would not be attending the hearing and is happy for the panel to proceed in her absence.*'

This was confirmed again in another telephone call on 5 March 2021. The telephone note states:

> '*I spoke to* [Mrs Ihejieto] *to ask whether she objects to the hearing taking place in her absence.* [Mrs Ihejieto] *confirmed that she does not hold any objections and she is happy 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)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Ihejieto. In reaching this decision, the panel has considered the submissions of Mr Earnshaw, and the advice of the legal assessor. It has 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 Mrs Ihejieto;
- Mrs Ihejieto 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;
- Two witnesses have attended today to give live evidence, and others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2017 and 2018;
- 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 and the hearing previously scheduled for March 2020 did not go ahead.

There is some disadvantage to Mrs Ihejieto in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. Mrs Ihejieto has addressed the allegations in her written representations of 23 December 2019 and the panel will consider these representations with care. 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. Furthermore, the limited disadvantage is the consequence of Mrs Ihejieto's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

That you, a registered nurse:

1) On 10 February 2017 slapped or hit Colleague 1. **[Proved]**

2) On 14 July 2017:-

   (a) shouted “What are you doing” or words to that effect at Patient A’s daughter; **[Proved]**

   (b) shouted at Patient A. **[Proved]**

3) On 4 September 2017 failed to insert a cannula into Patient B’s hand in a competent manner in that you caused or permitted a piece of plastic to be partially inserted into Patient B’s hand. **[Not Proved]**

4) On 19 July 2018 entered an operating theatre and/or scrub-up area;

   (a) when you were wearing your ward uniform and not wearing scrubs; **[Proved]**

   (b) and refused to leave the area promptly when requested to do so. **[Proved]**

5) On 31 July 2018 failed to safely prepare Patient C to receive intravenous infusion treatment in that, prior to treatment, you did not conduct (or instruct another to conduct) the following tests and observations:
   [Proved by admission in its entirety]

   (a) urine dip stick test;

   (b) blood sugar test;

   (c) temperature;

(d) pulse;

(e) blood pressure.

6) On 31 July 2018 failed to check the Care Record Document to ascertain whether the tests/observations referred to in Charge 5 above had been carried out. **[Proved by admission]**

7) On 31 July 2018 failed to take Patient C's blood prior to commencement of the intravenous infusion. **[Proved by admission]**

8) On 31 July 2018 failed to insert a cannula into Patient C's hand in a competent manner. **[Proved]**

9) On 31 July 2018 ignored the instruction of the nurse in charge of the shift to desist from treating Patient C. **[Proved]**

10) On 31 July 2018 manually handled Patient D in an incorrect manner in that you held her by her arm(s) in order to move her. **[Proved]**

11) On 31 July 2018 failed to document the incident referred to in Charge 10 above in a clinical incident form or in the patient's notes. **[Proved]**

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

Decision and reasons on application to admit written statement into evidence

The panel heard an application made by Mr Earnshaw under Rule 31 to allow the written statement of Patient C into evidence. Patient C was not present at this hearing and, whilst the NMC had made repeated efforts to ensure that this witness would give evidence, Patient C made it clear from the beginning that he did not want to attend, nor did he want to give evidence during the hearing. Mr Earnshaw submitted that Patient C's witness statement is relevant to the charges and directly addresses the issues in charges 7, 8 and 9.

In the preparation of this hearing, the NMC had indicated to Mrs Ihejieto that it was not the NMC's intention for Patient C to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Patient C, Mrs Ihejieto made the decision not to attend this hearing. Furthermore, Mr Earnshaw took the panel to a telephone conversation between the NMC Case Officer and Mrs Ihejieto. The Telephone note, dated 16 February 2021, states the following:

> '*Call to Cordelia to ask whether she gives her consent for Patient C's NMC witness statement to be read at the upcoming substantive hearing. Cordelia informed me that we can read whatever we want and that she gives her consent. I thanked her for her cooperation.*'

On this basis Mr Earnshaw advanced the argument that there was no lack of fairness to Mrs Earnshaw in allowing Patient C's written statement into evidence.

The panel accepted the advice of the legal assessor. The legal assessor advised that the panel must specifically consider the issue of 'fairness' before admitting the evidence and drew the panel's attention to the relevant principles articulated in the following cases: *Bonhoeffer v GMC* [2011] EWHC 1585 (Admin); *Thorneycroft v NMC* [2014] EWHC 1565 (Admin); *NMC v Ogbonna* (2010) EWCA Civ 1216; and *Razzaq v Financial Services Authority* [2014] EWCA Civ 770.

The panel gave the application in regard to Patient C serious consideration. The panel noted that Patient C's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by him.

The panel considered that as Mrs Ihejieto had been provided with a copy of Patient C's statement and, as the panel had already determined that Mrs Ihejieto had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel noted that Patient C's statement was the only direct evidence relevant to charge 8. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from testing the evidence of Patient C and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Patient C, but would give to it what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The charges arose whilst Mrs Ihejieto was employed as a registered nurse by University Hospital Bristol NHS Foundation Trust (the Trust). Mrs Ihejieto started working at the Trust in June 2003.

The NMC received a referral from the Trust on the 27 November 2018 alleging the following incidents:

- On 10 February 2017 Mrs Ihejieto slapped Colleague 1 while Colleague 1 was speaking to a patient. Mrs Ihejieto states that she tapped Colleague 1 to get her attention;
- On 14 July 2017 Ms 7 accompanied her mother, Patient A, to the Hospital and sat with her in the waiting room as her mother was agitated. It is alleged that Mrs Ihejieto was not happy with this and shouted at Ms 7 and Patient A;
- On 4 September 2017 tried to insert a cannula into Patient B's hand, but ultimately failed and allowed a piece of plastic to be partially inserted into Patient B's hand;
- On 19 July 2018, when trying to speak to a doctor, entered the scrub-up area and operating theatre whilst wearing her ward uniform, which is in contrast to the Trusts policy. It is further alleged that when advised to leave Mrs Ihejieto refused to do so.
- On 5 July 2018 Mrs Ihejieto failed to safely prepare Patient C to receive intravenous infusion treatment by failing to conduct a urine drip stick test, blood sugar tests, and taking Patient C's temperature, pulse and blood pressure. Following this on 31 July 2018 Mrs Ihejieto failed to check the Care Record Document to ascertain whether the tests and observations had been carried out and subsequently failed to take Patient C's blood prior to commencement of the intravenous infusion.
- On 31 July 2018 Mrs Ihejieto failed to insert a cannula into Patient C's hand resulting in excessive bleeding and the patient as well has his wife being agitated and distressed. When asked by the nurse in charge of the shift to desist from treating patient C, Mrs Ihejieto ignored the instruction.
- On 31 July 2018 Patient D had a fall after fainting. Mrs Ihejieto tried to help Patient D up by herself not following the Trust's manual handling policy and without asking for help. Mrs Ihejieto subsequently failed to record the incident in her nursing notes and to complete a clinical incident form.

The incidents were investigated by the Trust and as a result Mrs Ihejieto was suspended on 3 August 2018. Mrs Ihejieto has not worked for the Trust since.

Facts

At the outset of the hearing, the panel noted the Case Management Form (CMF) submitted by Mrs Ihejieto, signed and dated 23 December 2019. In the CMF Mrs Ihejieto made admissions to charges 5, 6 and 7 by ticking the box '*Yes*' when answering the question '*Do you admit the facts alleged in the charge above?*'. Furthermore, the panel noted that Mrs Ihejieto has given clear written admissions with regard to charge 5 and charge 7.

The panel therefore finds charges 5, 6 and 7 proved in their entirety, by way of Mrs Ihejieto's admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Earnshaw on behalf of the NMC and the written representations provided by Mrs Ihejieto.

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

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: Matron, University Hospital Bristol NHS foundation Trust, Bristol Dental and Eye Hospital
- Patient B: Patient at Bristol Eye Hospital

- Ms 2 — Theatre Nurse, Bristol Eye Hospital
- Colleague 1 — Nursing Assistant, Bristol Eye Hospital
- Ms 3 — Registered Nurse, Bristol Eye Hospital
- Mr 4 — Ward Manager, Bristol Eye Hospital
- Mr 5 — Nursing Assistant, Bristol Eye Hospital
- Ms 6 — Consultant Ophthalmic Surgeon, Bristol Eye Hospital
- Ms 7 — Patient A's relative

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 considered the evidence of the witnesses and made the following conclusions:

Ms 1: The panel considered the evidence of Ms 1 to be credible. Ms 1 investigated the incidents at the Trust, but was not a direct witness to any of the incidents. The panel found that Ms 1 was able to give the panel an overview of the incidents and the investigation. Her oral evidence was consistent with her written evidence. The panel found Ms 1 to be honest, forthright and fair to Mrs Ihejieto when giving evidence.

Patient B: The panel considered the evidence of Patient B to be helpful. The panel found that Patient B was fair to Mrs Ihejieto. He was straight forward, balanced and clear and his oral evidence was consistent with his written evidence.

Ms 2: The panel considered the evidence of Ms 2 to be credible. Ms 2 was a direct witness to the incident of Mrs Ihejieto entering the operating theatre and/or scrub area in her uniform instead of scrubs. Her oral evidence was consistent with her written evidence and she did her best to answer the panel's questions. However, there were several interruptions during her oral evidence which caused some disruption.

Colleague 1: The panel considered the evidence of Colleague 1 to be credible. The panel found that there were some inconsistencies between Colleague 1's initial statement to the internal investigation and her written and oral evidence to the NMC. However, the panel did not consider this to be misleading but rather a development of Colleague 1's thoughts and considerations changing over time.

Ms 3: The panel considered the evidence of Ms 3 to be credible. The panel found Ms 3 to be honest and straightforward, her oral evidence was consistent with her written evidence. She did her best to help the panel.

Mr 4: The panel considered the evidence of Mr 4 to be credible. The panel found Mr 4's evidence to be straightforward to the limited direct knowledge he had about the events. He was clear in his evidence and was able to give the panel background information. Overall the panel found Mr 4 to be helpful.

Mr 5: The panel considered the evidence of Mr 5 to be credible. The panel found Mr 5 to be reliable, helpful and honest. He did his best to assist the panel.

Ms 6: The panel considered the evidence of Ms 6 to be credible. The panel found Ms 6 to be consistent and clear. Her oral evidence was in line with her written statement. The panel found her to be reliable, truthful and doing her best to assist the panel. She was honest when she did not know and admitted if it was not her area of expertise.

Ms 7: The panel considered the evidence of Ms 7 to be credible. The panel found Ms 7 to be honest and very clear. Her oral evidence was consistent with her written evidence. Ms 7 was fair to Mrs Ihejieto despite being upset about the events.

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

Charge 1

1) On 10 February 2017 slapped or hit Colleague 1.

This charge is found proved.

In reaching this decision, the panel took into account Colleague 1's written and oral evidence, the report of the local investigation and Mrs Ihejieto's written explanation of the event.

The panel noted that there is no disagreement that some physical contact took place between Mrs Ihejieto and Colleague 1. Mrs Ihejieto described the incident as tapping on Colleague 1's shoulder.

The panel first established what it meant to slap or hit. The panel agreed that to hit means having some force behind the action and that slapping meant hitting with an open hand. However, the panel acknowledged that these definitions can be very subjective.

The panel noted some inconsistencies within Colleague 1's written statements as to whether or not the action had hurt. The panel heard in Colleague 1's oral evidence that the hit/slap was not hurtful: '*It did not hurt, but it jolted me*'. However, the panel determined that at a minimum, Mrs Ihejieto had forcefully interrupted Colleague 1 while she was speaking to a patient. The panel further heard evidence that the hit/slap was shocking, forceful and therefore significant enough for Colleague 1 to raise the issue, report the incident and give a statement.

On balance, the panel preferred Colleague 1's version of events and concluded that Mrs Ihejieto's actions were forceful enough to be considered a hit or a slap.

The panel was therefore satisfied that it is more likely than not that on 10 February 2017, Mrs Ihejieto slapped or hit Colleague 1.

Charge 2a)

2) On 14 July 2017:
   (a) shouted "What are you doing" or words to that effect at Patient A's daughter;

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Ms 7, the complaint to the Hospital in e-mail form, dated 27 July 2017, and Mrs Ihejieto's written explanation of the event.

The panel found Ms 7's evidence to be clear and consistent with the contemporaneous e-mail complaint to the hospital. The panel heard that Ms 7 accompanied her mother, who was hard of hearing and had a diagnosis of Alzheimer's disease, to the hospital for an eye operation on 14 July 2017. Patient A was agitated by the early start and the unfamiliar

surroundings. There was an interaction with the registrant which Ms 7 describes in her email to the Trust, dated 27 July 2017 that:

> '[Mrs Ihejieto] *came rushing over* […] *and began shouting in my face telling me it was against hospital procedure for me to stay with my mum. She was very loud and threatening and I asked her to stop shouting and I asked her to stop being so rude.*'

Further, in her witness statement, dated 8 May 2019, Ms 7 stated:

> '*The male nurse was stood behind* [Mrs Ihejieto] *during my conversation with her and he mouthed 'I am so sorry'.'*

The panel noted Mrs Ihejieto's explanation that this is her voice and that '*people regard my voice as shouting but I am really sorry, for that I don't mean to* shout'.

Ms 7 acknowledged that Mrs Ihejieto could have been shouting as her mother was hard of hearing. However, the panel heard from Ms 7 that Mrs Ihejieto did not change her level of volume when speaking to Ms 7, who is not hard of hearing. Ms 7 also described Mrs Ihejieto as speaking to her in a calm manner once she returned to her desk. The panel therefore concluded that there was a clear difference in the manner and volume of speaking to Ms 7 and her mother, Patient A, on the two occasions. The panel further noted that Ms 7 described the incident as traumatic and that she was tearful due to Mrs Ihejieto's manner and further that Patient A was distressed and agitated.

The panel preferred Ms 7's description of the events to Mrs Ihejieto's explanation in this case.

The panel was therefore satisfied that on 14 July 2017 Mrs Ihejieto shouted "What are you doing" or words to that effect at Patient A's daughter.

Charge 2b)

2) On 14 July 2017:
(b) shouted at Patient A

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Ms 7, the complaint to the Hospital in e-mail form, dated 27 July 2017, and Mrs Ihejieto's written explanation of the event.

The panel took into account Ms 7's e-mailed complaint that:

> '*I tried to explain that my mum was not capable of being left alone but* [Mrs Ihejieto] *then turned to my mum and shouted right in her face 'What's your name? what* [sic] *your date of birth?'. My mum was very agitated by this point and answered her whilst looking a* [sic] *me. The staff nurse then looked back at me and said something along the lines of, 'You see she can answer our questions.'*
> […]
> *Mum then became very agitated and said she wanted to leave and it took me a long time to calm her down in order to make her stay.* '

For the same reasons as already stated in charge 2(a) this charge is found proved.

The panel was therefore satisfied that on 14 July 2017 Mrs Ihejieto shouted at Patient A.

Charge 3)

3) On 4 September 2017 failed to insert a cannula into Patient B's hand in a competent manner in that you caused or permitted a piece of plastic to be partially inserted into Patient B's hand.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Patient B, the complaint to the Hospital in e-mail form, dated 26 September 2017, and Mrs Ihejieto's written explanation of the incident.

The panel noted Patient B's evidence and his description of the incident. The panel noted that Patient B was seemingly distressed by the overall incident. The panel accepted that it was clear that Patient B thought that Mrs Ihejieto needed help with the process as he thought that she did not have any experience of inserting a cannula. However, the panel noted that Patient B sounded slightly confused when describing the cannula to the panel and that he was had not been wearing his glasses at the time of the incident which led to him not being able to describe the black '*thing*' he perceived as a piece of plastic. The panel noted that there was no other evidence provided by the NMC that there was indeed a piece of plastic inserted into Patient B's hand. There were two subsequent nurses attempting to insert the cannula into Patient B's hand and there was no evidence before the panel that one or both of them reported seeing a piece of black plastic. The panel noted that when a cannula is being inserted, even incorrectly, some blood may enter the cannula, which can look black, especially if your sight is impaired. The panel therefore concluded that there was no evidence before it that a piece of plastic was inserted into Patient B's hand whilst Mrs Ihejieto attempted to insert a cannula into his hand.

The panel was therefore not satisfied that on the balance of probabilities on 4 September 2017, Mrs Ihejieto failed to insert a cannula into Patient B's hand in a competent manner

in that she caused or permitted a piece of plastic to be partially inserted into Patient B's hand

Charge 4a)

4) On 19 July 2018 entered an operating theatre and/or scrub-up area;

(a) when you were wearing your ward uniform and not wearing scrubs;

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Ms 2, the Trust's Infection Control Policy, the Trust's Theatre Standards Policy and Mrs Ihejieto's written explanation of the incident.

The panel noted Mrs Ihejieto's explanation that she entered the '*cubicle*' area of the theatre only after the doctor inside opened the door and asked her to come in.

The panel heard Ms 2's description of the set-up of the theatre and the scrub area and that there was no door between the theatre and the scrub area. The panel noted that Ms 2 was very clear in her description of the incident and how Mrs Ihejieto entered the scrub-up area in her uniform instead of scrubs. Ms 2 was able to clearly describe the process of changing into scrubs and back into uniform when entering and leaving the scrub-up and theatre area.

In this case the panel preferred Ms 2's description of events, as it was consistent with her written evidence and the panel was able to test the evidence in person. The panel also bore in mind that Ms 2 had submitted her written concern to the Trust on 19 July 2018. It was therefore satisfied that there was enough evidence before it to prove that Mrs Ihejieto entered the scrub area of the theatre in her nursing uniform instead of scrubs.

The panel was therefore satisfied that it was more likely than not that on 19 July 2018 Mrs Ihejieto entered an operating theatre and/or scrub-area when she was wearing her ward uniform and not wearing scrubs.

Charge 4b)

4) On 19 July 2018 entered an operating theatre and/or scrub-up area;

(b) and refused to leave the area promptly when requested to do so.

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Ms 2, the Trust's Infection Control Policy, the Trust's Theatre Standards Policy and Mrs Ihejieto's written explanation of the incident.

The panel reminded itself of its findings in charge 4(a).

The panel found that Ms 2 was very clear when describing the incident and that Mrs Ihejieto refused to leave the area when asked to do so. Again, the panel preferred Ms 2's evidence over the statement provided by Mrs Ihejieto.

The panel was therefore satisfied that it was more likely than not that on 19 July 2018 Mrs Ihejieto entered an operating theatre and/or scrub-up area and refused to leave the area promptly when asked to do so.

Charge 8)

8) On 31 July 2018 failed to insert a cannula into Patient C's hand in a competent manner.

This charge is found proved.

In reaching this decision, the panel took into account Patient C's written statement, as well as the written and oral evidence of Colleague 1 and Ms 3. The panel also took into account the Datix entry for the incident, the photograph of Patient C's pillow, the accounts of the incident given to the local investigation and Mrs Ihejieto's written explanation of the incident.

The panel noted Patient C's witness statement:

> '*Mrs Ihejieto tried to insert the cannula two to three times. She didn't have any of the things that she needed, all of the other nurses beforehand had different bungs and things to stop the blood. As well as different coloured pieces of equipment, none of that had been organised.*
>
> *Mrs Ihejieto stuck the needle in the back of my hand with no means of stopping the blood that was pouring out. She had to go off and get some medical equipment that she should have had beforehand. She came back and then there was something else that was missing that she should have had, a sticky patch that was supposed to keep the needle in place.*
>
> *Mrs Ihejieto left the room roughly three times during the procedure. The blood was coming out and whilst she went off to get the tubes there was no way of stopping it.* […]'

The panel also noted that Patient C described his wife becoming '*hysterical*' due to the amount of blood and that she went to get some help.

The panel noted that several witnesses stated that Patient C's wife came and asked for help because of her concerns about the cannulation of Patient C. However, Ms 3 stated in her oral evidence that the blood was gone and cleaned up by the time she arrived.

The panel noted that they were not able to hear directly from Patient C or his wife. However, it was of the view that there was enough evidence before it to conclude that the cannulation of Patient C was not carried out in a competent manner.

The panel was therefore satisfied that on the balance of probabilities on 31 July 2018 Mrs Ihejieto failed to insert a cannula into Patient C's hand in a competent manner.

Charge 9)

9) On 31 July 2018 ignored the instruction of the nurse in charge of the shift to desist from treating Patient C.

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague 1 and Ms 3. The panel also took into account the Datix entry for the incident, the accounts of the incident given to the local investigation and Mrs Ihejieto's written explanation of the incident.

The panel noted Ms Ihejieto's statement to the local investigation in which she states:

> '*There was no time the charge nurse asked me to desist from treatment of the patient and I refused her, never and there was no comment made to me by the patient or his wife, regarding any harm/distress.*'

The panel also noted the written evidence of colleague 1, which she confirmed during her oral evidence:

> '[Mrs Ihejieto] *continued to come into the day unit where Patient C was sat. She attempted to attach the patient to the intravenous drip even though we had already*

told her not to. Both Patient C and his wife were very distressed and taken aback. [Ms 3] *and I were present and we asked her not to.*'

The panel noted that this is confirmed by Ms 3 in her statement:

'*The nursing assistant moved the patient into the day unit where I was working. I was finishing off a task when* [Mrs Ihejieto] *came into the day unit with the IV stand and the methylprednisolone. She went over to the patient and I told* [Mrs Ihejieto] *to leave it as I would do the infusion.* [Mrs Ihejieto] *ignored me and she carried on by connecting the patient to the IV drip. I allowed her to carry on. The patients in the bay would have heard my conversation with* [Mrs Ihejieto].
[…] *I told her not to take the patient's bloods as I would do it*. […] [Mrs Ihejieto] *left the bay and then came back, around 10 minutes later with a tray of equipment which are used to take bloods. I did not say anything further to her as I had already asked her to leave but she had ignored me.*'

The panel was of the view that Colleague 1 and Ms 3's statement are consistent and were also confirmed when tested during their oral evidence. The panel also noted that several witnesses gave background information confirming that Mrs Ihejieto had a habit of not following instructions.

The panel was therefore satisfied that it was more likely than not that on 31 July 2018 Mrs Ihejieto ignored the instruction of the nurse in charge of the shift to desist from treating Patient C.

Charge 10)

10) On 31 July 2018 manually handled Patient D in an incorrect manner in that you held her by her arm(s) in order to move her.

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Mr 5 and Ms 6 as well as the statements given in the local investigation by the Trust, the Trust's Manual Handling Policy and Mrs Ihejieto's written explanation of the incident.

The panel noted that Mrs Ihejieto has stated:

> '*I was behind my patient, holding her by the sides und her arms trying to get a chair to sit her on as she told me that she does not want to go to the Loo* [sic] *any longer.*'

The panel heard that both Mr 5 and Ms 6 were sitting at the nursing station when they heard a '*clattering sound come from the patient's room*' and both confirmed that Patient D's lunch tray had been knocked over.

The panel noted Mr 5's written statement, which he confirmed during his oral evidence:

> '*I went straight into the room to find that* [Mrs Ihejieto] *was stood behind the patient who had started to fall. She had both of her arms underneath Patient D's arms trying to drag her back up.*
> *The Consultant* [Ms 6] *and I told* [Mrs Ihejieto] *to stop trying to pull the patient back up by her arms as this could cause injury to the patient and/or* [Mrs Ihejieto]. *She ignored us.* [Mrs Ihejieto] *should not have dragged the patient up off the floor by her arms. She should have to help to move the patient and she should have used patient handling equipment such as a hoist.*'

This was confirmed by Ms 6 in her written statement, and also in her oral evidence:

> '*I watched* [Mrs Ihejieto] *try to help the patient into a chair and she did so by pulling her by the elbow. The patient was frail and had compression stockings on. Her feet were slipping out from beneath her. I asked* [Mrs Ihejieto] *to stop as I was worried the lady would fall or sustain an injury. When she persisted with trying to get the*

lady into the chair by pulling her by the arm, myself and others (I cannot recall who), asked [Mrs Ihejieto] *to leave and let us help the patient into bed using a hoist.*'

The panel considered that Mrs Ihejieto's description of the manual handling of Patient D is very similar to the description by Mr 5 and Ms 6 and it preferred their evidence in this instance.

The panel acknowledged that Mrs Ihejieto's initial concern may have been to limit Patient D's fall in the first instance. However, it noted that Mrs Ihejieto was not following the Trust's Manual Handling Policy by holding Patient D in that way by herself.

The panel was therefore satisfied that on the balance of probabilities on the 31 July 2018 Mrs Ihejieto manually handled Patient D in an incorrect manner in that she held her by her arm(s) in order to move her.

Charge 11)

11) On 31 July 2018 failed to document the incident referred to in Charge 10 above in a clinical incident form or in the patient's notes.

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Mr 4, Mr 5 and Ms 6 as well as the statements given in the local investigation by the Trust, the Clinical notes for Patient D completed by Ms 6 on 31 July 2018, Nursing notes for Patient D completed by Mrs Ihejieto, a Fall Risk Assessment for Patient D and Mrs Ihejieto's written explanation of the incident.

The panel noted that Ms 6's clinical notes stated that Patient D had a fall due to fainting, that she was helped to lie down by Mrs Ihejieto and was later hoisted back into bed.

The panel also noted the nursing notes completed by Mrs Ihejieto, which do not mention a fall. The panel noted that in her written explanation Mrs Ihejieto states that she did not think she needed to document anything as '*there was no incidence that happened as to document in the note, or complete incidence form; there was no fall, collapse of even fainting*' [sic].

However, a fall risk assessment was completed by Mr 5 dated 31 July 2018 assessing that patient was at risk.

The panel already established in Charge 10 that it preferred Mr 5 and Ms 6's evidence to that of Mrs Ihejieto. The panel accepted the evidence of Ms 6 and Mr 4 that there was a duty to document any incident that had the potential to cause harm. The panel was therefore satisfied that there was an incident involving Patient D that should have been documented by way of a clinical incident form and in the patient's nursing notes.

The panel was therefore satisfied that it was more likely than not that on 31 July 2018 Mrs Ihejieto failed to document the incident referred to in Charge 10 above in a clinical incident form or in the patient's notes.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Ihejieto'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 suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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

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

Mr Earnshaw identified the relevant standards where Mrs Ihejieto's actions amounted to misconduct. He submitted that not all of the charges in isolation may be regarded as misconduct, however, looked at cumulatively they can be seen as serious misconduct.

Submissions on impairment

Mr Earnshaw 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).

Mr Earnshaw submitted that although there has been some engagement from Mrs Ihejieto regarding the hearing it has not been positive engagement. He accepted that Mrs Ihejieto stated that she is sorry and made some admissions, however, he submitted that Mrs Ihejieto has not reflected on her misconduct nor attempted to understand the effect of her behaviour on her patients, their relatives, her colleagues and the profession as a whole.

Mr Earnshaw submitted that Mrs Ihejieto has not remediated her misconduct. She has not worked as a registered nurse since 2018 due to personal circumstances. He submitted that under these circumstances Mrs Ihejieto has not yet remediated her misconduct, nor is it likely that she will in the future.

Mr Earnshaw therefore submitted that there is a risk of repetition of her behaviour in the future, particularly given Mrs Ihejieto's apparent inability to listen to others calmly and take instructions. Furthermore, there is no reflective piece before the panel outlining that Mrs Ihejieto understands her misconduct.

Mr Earnshaw submitted that in this case three of the limbs of the *Shipman Test* are engaged. He therefore invited the panel to find that Mrs Ihejieto's practise is currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

'***1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.6 recognise when people are anxious or in distress and respond compassionately and politely

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

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

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

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

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

To achieve this, you must:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel determined to look at the charges individually first and then cumulatively.

In relation to charge 1 the panel was of the view that whilst hitting a colleague on the shoulder to get their attention was conduct that fell short, it was not serious enough to amount to misconduct of itself.

When considering charge 2 (a) and 2 (b) the panel was of the view that shouting at a vulnerable patient and their relative, when the relative is not hard of hearing, fell far short of the conduct expected of a registered nurse and did amount to misconduct.

The panel then considered charge 4 (a) and (b). The panel was of the view that entering a scrub-up area in ward uniform breached Trust policy and was not in line with the conduct expected of a registered nurse, but not serious enough to amount to misconduct. However, the panel was of the view that refusing to leave the area after being told to do so falls far below the standard expected of a registered nurse and does amount to misconduct. The panel concluded that taken together, charge 4 (a) and 4 (b) do amount to misconduct.

The panel looked at charges 5 (a), (b), (c), (d), (e), 6 and 7 together, as these related to the same incident. It was of the view that Mrs Ihejieto failed to do basic observations that were expected to be done before determining if it is safe to give an infusion. The panel noted, that Mrs Ihejieto again failed to follow instructions. The panel therefore determined that her actions fell far below the standard expected of a nurse and that charge 5, as a whole, charge 6 and 7 amounted to misconduct.

The panel then went on to consider charge 8. The panel noted that inserting a cannula is a regular routine activity for a registered nurse but accepted that it is not always straightforward. The panel found that although it was not done competently but in a disorganised way, the patient did not suffer any injury. The panel therefore concluded that not being able to insert a cannula on the first try does not amount to misconduct.

In considering charge 9 and its finding that Mrs Ihejieto did not desist from treating a patient after being told to do by the nurse in charge, the panel regarded this behaviour as

falling seriously short of what is expected of a registered nurse and amounted to misconduct.

Lastly, the panel considered charges 10 and 11 together. The panel was of the view that Mrs Ihejieto not only put the patient at risk of harm, but also herself, her colleagues and the relative of the patient. The panel noted that this was a frail elderly patient who was suffering from nose bleeds post operation. Mrs Ihejieto again failed to follow instructions and fell far below the standard expected of a registered nurse. The panel was therefore of the view that her poor manual handling and her failure to document the incident correctly amounted to misconduct.

The panel was of the view that although not all charges individually amounted to misconduct, cumulatively Mrs Ihejieto's actions fell far below the standard expected of a nurse and do amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Ihejieto's fitness to practise is currently 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 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 and were caused physical and emotional harm as a result of Mrs Ihejieto's misconduct. Mrs Ihejieto's misconduct had breached fundamental tenets of the nursing profession, including those of safe and effective nursing care and treating patients and colleagues with dignity and sensitivity, and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that although Mrs Ihejieto has apologised for her actions and admitted some of the charges she has not shown any understanding of the impact of her actions on her patients, their relatives, her colleagues and the profession as a whole. The panel had no reflective piece before it to show that Mrs Ihejieto has reflected on her actions or gained insight since the incidents. The panel was of the view that although Mrs Ihejieto had been criticised by her colleagues and been asked to follow her senior's instructions, she has not taken on board any of that feedback, adjusted her behaviour or learned from her mistakes. The panel was therefore of the view that there was only a very limited degree of insight.

The panel was satisfied that the clinical misconduct in this case is capable of remediation. However, Mrs Ihejieto has not worked as a registered nurse since 15 October 2018 and was therefore not able to show that her competencies have improved and that she has remediated her misconduct. The panel noted that Mrs Ihejieto stated that due to personal circumstances she is not intending to work as a registered nurse in the future and it had no indication before it to show that Mrs Ihejieto is intending to remediate her misconduct. Further, the panel was of the view that much of the misconduct displayed by Mrs Ihejieto related to her attitude towards other people and following instructions. The panel was of the view that remediation of this kind of misconduct is difficult, although not impossible.

Therefore, the panel is of the view that there is a risk of repetition based on the very limited insight and the lack of remediation and reflection. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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.

Therefore, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Ihejieto's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Ihejieto's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Ihejieto off the register. The effect of this order is that the NMC register will show that Mrs Ihejieto has been struck-off the register.

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

Submissions on sanction

Mr Earnshaw informed the panel that in the Notice of Hearing, dated 3 March 2021, the NMC had advised Mrs Ihejieto that it would seek the imposition of a striking-off order if it found her fitness to practise currently impaired.

Mr Earnshaw submitted that a caution order in this case would not be appropriate due to the public protection and public interest issues identified. He submitted that a conditions of practice order may have been appropriate with greater engagement and acceptance of all the failings by Mrs Ihejieto. However, he submitted that a conditions of practice order would be impractical due to the very limited engagement.

Mr Earnshaw then submitted that the facts found proved were not a single incident of misconduct and that there does appear to be an attitudinal problem with an inability to

follow instructions. He submitted that Mrs Ihejieto has insufficient insight and that therefore there is a risk of repeating her failings. He submitted that, although the panel found that some of the failings on their own did not amount to misconduct, cumulatively they amount to serious misconduct and that the failings appear to get worse rather than better. Mr Earnshaw therefore submitted that a suspension order would not be appropriate in this case.

Mr Earnshaw submitted that the unwillingness of Mrs Ihejieto to follow instructions makes working in a team in a caring environment much more difficult. He therefore invited the panel to impose a striking-off order.

Decision and reasons on sanction

Having found Mrs Ihejieto'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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Very limited insight into failings;
- A pattern of misconduct over a period of time; and
- Conduct which put patients at risk of suffering harm.

The panel looked at mitigating features and acknowledged that Mrs Ihejieto admitted some of the charges and provided the panel with limited apologies. However, the panel found that these admissions and apologies were partial and qualified and therefore it could not consider them as mitigation.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the ongoing public protection concerns. 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 Mrs Ihejieto's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Ihejieto's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that 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 Mrs Ihejieto's registration would be a sufficient and appropriate response. The panel found that there was evidence of some attitudinal problems and was of the view that these would undermine the effectiveness of any conditions imposed. Further, although there are some areas of Mrs Ihejieto's practice that could potentially be addressed through assessment or retraining they are outweighed by the more serious misconduct found proved which is not easily remediable. The panel was of the view that the serious misconduct identified in this case was not something that could be addressed through retraining. Additionally, the panel notes that there is no evidence before it to show that Mrs Ihejieto would be willing to retrain or to address the attitudinal concerns, since in her written statement she does not accept that there were things she did wrong. Therefore, the panel is of the view that there are no practical or workable conditions that could be formulated which would adequately address the seriousness of this case and protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

As already stated the panel found that there were several instances of misconduct in different areas of Mrs Ihejieto's nursing practice. Additionally, Mrs Ihejieto showed a poor attitude towards senior staff repeatedly failing to follow instructions.

The panel also found that in her written responses to the charges Mrs Ihejieto did not accept any concerns with her practice in many instances, and where she did acknowledge failings she deflected responsibility by finding excuses for her behaviour.

The panel noted that there has not been any repetition of the misconduct shown, however, Mrs Ihejieto has not been working as a registered nurse since being suspended by the Trust in October 2018.

Due to all this, the panel was of the view that there is a significant risk of Mrs Ihejieto repeating her behaviour.

Mrs Ihejieto's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel determined that the serious breaches of the fundamental tenets of the profession evidenced by Mrs Ihejieto's actions are fundamentally incompatible with her remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel was of the view that Mrs Ihejieto's attitude towards other staff and her repeated failure to follow instructions fundamentally conflicts with her ability to work as a member of a team. The panel considered that teamwork is a corner stone of the nursing profession and therefore this raises fundamental questions about Mrs Ihejieto's professionalism.

The panel bore in mind its earlier finding that Mrs Ihejieto's failings breached numerous areas of the code, including treating patients and colleagues with kindness, respect and compassion.

The panel found that there was no meaningful engagement by Mrs Ihejieto with the NMC or this hearing, limited insight and no remediation. In these particular circumstances of this case the panel was of the view that public confidence in the profession cannot be maintained should Mrs Ihejieto remain on the register. Further, the panel was of the view that Mrs Ihejieto has breached fundamental professional standards and the public would be shocked to find that her actions did not warrant a striking-off order.

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

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

This will be confirmed to Mrs Ihejieto in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Earnshaw. He submitted that an interim order is necessary to protect the public and is otherwise in the public interest for the reasons identified earlier by the panel in their determination until the striking off order comes into effect. He therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the ongoing public protection concerns. It determined for the same reasons as set out in its decision for the substantive order 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 striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

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

That concludes this determination.