Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
07 June 2021 – 15 June 2021

Virtual Hearing

Name of registrant:	Emmanuel Brass Yaji
NMC PIN:	92E0108O
Part(s) of the register:	Nursing – Sub part 1 RN1: Registered Nurse – Adult (19 May 1992)
Area of registered address:	Crewe
Type of case:	Misconduct
Panel members:	John Penhale (Chair, Lay member) Jan Bilton (Lay member) Susan Tokley (Registrant member)
Legal Assessor:	Nicholas Leviseur
Panel Secretary:	Roshani Wanigasinghe
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Mr Yaji:	Not present and not represented
Facts proved:	Charges 1c, 2a, 2b, 2d, 4 in its entirety, 5a, 5b, 6 in its entirety, 7, 8, 9 and 10
Facts not proved:	Charges 1a, 1b, 2c, 3 and 5c
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 Mr Yaji was not in attendance nor was he represented in his absence.

The panel noted that under the recent amendments made to the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (as amended) ("the Rules") during the COVID-19 emergency period, notice of hearing must be sent to a registrant's registered address either by recorded delivery and first class post or to a suitable email address on the register.

The panel was informed that notice of this hearing was sent to Mr Yaji on 7 May 2021 to his email address on the register.

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

Mr Kennedy, 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 Mr Yaji has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Yaji

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

Mr Kennedy submitted that the NMC had attempted to call/email Mr Yaji on a number of occasions regarding these proceedings, but had been unsuccessful. He stated that Mr Yaji had not provided any responses to the allegations in this case. Mr Kennedy submitted, as a consequence of Mr Yaji's disengagement from these proceedings, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Yaji. In reaching this decision, the panel has considered the submissions of Mr Kennedy and the advice of the legal assessor. It took account of the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 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 Mr Yaji;
- Mr Yaji has not engaged with the NMC and has not responded to any of the communications sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;

- Eight witnesses are arranged to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the patients who need their professional services;
- The charges relate to events that occurred in 2019;
- 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 Mr Yaji in proceeding in his absence. The panel noted that the evidence upon which the NMC relies will have been sent to him via his registered email address, and that he had not made any formal responses to the allegations. The panel noted that Mr Yaji will not be able to challenge the evidence relied upon by the NMC in person at this hearing and will not be able to give evidence on his own behalf due to non-attendance. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Yaji's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge (as amended)

That you, a registered nurse, whilst employed at Station House Nursing Home;

1) On 6 January 2019 in relation to Resident A's Calcichew tablet;

    a) Did not administer a Calcichew tablet to Resident A between 18:00-18:30 as prescribed.
    [Charge found NOT proved]
    b) Incorrectly completed Resident A's MAR Chart to indicate that you had administered the medication between 18:00 -18:30 as prescribed.
    [Charge found NOT proved]
    c) Did not administer a Calcichew tablet to Resident A until after approximately 19:40. **[Charge found proved]**

2) On 7 January 2019 in relation to Resident B, you;

    a) Incorrectly opened a pain relieving patch.
    [Charge found proved]
    b) Did not immediately administer/place the patch on Resident B.
    [Charge found proved]
    c) Incorrectly signed the Controlled Drug Book indicating that the patch had been administered. **[Charge found NOT proved]**
    d) Did not destroy the patch **[Charge found proved]**

3) You actions in charge 2 c) above were dishonest in that you knew you had not administered the patch to Resident B, but sought to represent that you had.
    [Charge found NOT proved]

4) On 7 January 2019 after being instructed to dispose of Resident B's Oramorph, you;

    a) Did not dispose of the Oramorph;
    [Charge found proved]
    b) Did not remove the Oramorph from the drug cupboard.
    [Charge found proved]

5) On 14 January 2019;

    a) Did not take a swab of Resident C's toe. **[Charge found proved]**
    b) Did not complete the Unit diary stating that you had not taken a swab of Resident C's toe. **[Charge found proved]**
    c) Did not handover information that you had not taken a swab of Resident C's toe. **[Charge found NOT proved]**

6) On 14 January 2019 following Resident D suffering a fall;

    a) Did not inform Doctor 1 to examine/review Resident D
    [Charge found proved]
    b) Did not write in the GP/Unit diary that Doctor 1 had been asked and/or reviewed Resident D. **[Charge found proved]**
    c) Did not update the MFRA **[Charge found proved]**
    d) Did not complete a body map **[Charge found proved]**
    e) Did not complete a 72 hours post fall form **[Charge found proved]**
    f) Did not update Resident D's mobility care plan **[Charge found proved]**
    g) Incorrectly informed the Deputy Manager Colleague 1, that Doctor 1 had reviewed/examined Resident D. **[Charge found proved]**
    h) Incorrectly informed Deputy Manager Colleague 1 that Doctor 1 had "no concerns" with Resident D. **[Charge found proved]**

7) Your actions in charge 6 g) & h) were dishonest in that you knew that Doctor 1 had not examined/reviewed Resident D, but you sought to represent that he had.
[Charge found proved]

That you, a registered nurse, whilst employed by Bramley Health (the Employer) at Croham Place between 21 March 2019 & 9 May 2019;

8) Did not comply with paragraph 10 a) of the Interim Conditions of Practice Order imposed on 28 March 2019 by an Investigating Committee of the NMC, in that you;

    a) Between 28 March 2019 & 9 May 2019 did not disclose to your employer that you were subject to an Interim Conditions of Practice Order.
    [Charge found proved]

9) Did not comply with paragraph 2 a) of the Interim Conditions of Practice Order imposed on 28 March 2019 by an Investigating Committee of the NMC, in that you;

    a) On one or more occasion between 28 March 2019 & 9 May 2019 administered medication to Residents unsupervised, as listed in schedule 1.
    [Charge found proved]

10) Your actions in charges 8 and/or 9 were dishonest, in that you sought to conceal, that regulatory restrictions were placed upon your practice, from Bramley Health.
[Charge found proved]

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

Schedule 1

In relation to Resident 1

1) Administered Betamethasone valerate 0.1% cream to Resident 1 between 28 March - 7 May 2019

2) Administered Apixaban 5mg tablets to Resident 1 between 28 March 2019 – 7 May 2019

3) Administered Aripiprazole 5mg tablets to Resident 1 between 28 March 2019 – 7 May 2019

4) Administered Carbamazepine 200mg tablets to Resident 1 between 28 March 2019 – 7 May 2019

5) Administered Lansoprazole 30mg to Resident 1 between 28 March 2019 – 7 May 2019

6) Administered Nutilis clear powder to Resident 1 between 28 March 2019 – 7 May 2019

7) Administered Sodium Flouride Dental Paste SR 1.1% to Resident 1 between 28 March 2019 – 7 May 2019

In relation to Resident 2

8) Administered Aspirin 75mg tablets to Resident 2 between 28 March 2019 – 21 April 2019

9) Administered Carbamazepine 200mg tablets to Resident 2 between 28 March 2019 – 21 April 2019.

10) Administered Chlorhexidine Oral Spray SF 0.2% to Resident 2 between 28 March 2019 – 9 May 2019

11) Administered Clobazam 10mg tablets to Resident 2 between 28 March 2019 – 7 May 2019

12) Administered Colecal 400u+Calcium Carbonate 1.25 to Resident 2 between 28 March 2019 – 7 May 2019

13) Administered Folic Acid 5mg tablets to Resident 2 between 28 March 2019 – 7 May 2019

14) Administered Sodium Valproate 500mg tablets to Resident 2 between 28 March 2019 – 9 May 2019

In relation to Resident 3

15) Administered Baclofen 10 mg tablets to Resident 3 between 28 March 2019 – 9 May 2019

16) Administered Citalopram 20 mg tablets to Resident 3 between 28 March 2019 – 9 May 2019

17) Administered Clenit modulite 200mcg to Resident 3 between 28 March 2019 – 9 May 2019

18) Administered Co-codamol 30mg/500mg caplets to Resident 3 between 28 March 9 May 2019

19) Administered Folic Acid 5mg tablets to Resident 3 between 28 March 2019 – 9 May 2019

20) Administered Lansoprazole 16mg to Resident 3 between 28 March 2019 – 9 May 2019

21) Administered Salbutamol 100mcg to Resident 3 between 28 March 2019 – 9 May 2019

22) Administered Thiamine 100mg tablets to Resident 3 between 28 March 2019 – 9 May 2019

23) Administered Vitamin B Compound Strong Tablets to Resident 3 between 28 March 2019 – 9 May 2019

24) Administered Loratadine 10mg tablets to Resident 3 between 28 April 2019 – 9 May 2019

In relation to Resident 4

25) Administered Gabapentin 300mg to Resident 4 between 28 March 2019 – 7 May 2019

26) Administered Abidec drops to Resident 4 on 17 April 2019

27)

27) Administered Co-codamol 30mg/500mg caplets to Resident 4 between 28 March 2019 – 7 May 2019

28) Administered Hyocine patches 1mg/72hrs to Resident 4 between 20 April 2019 – 5 May 2019

29) Administered Moclobemide 150gm tablets to Resident 4 between 28 March 2019 – 5 May 2019

30) Administered Prosource TF Liquid 45ml to Resident 4 between 28 March 2019 – 8 May 2019

31) Administered Pegcare to Resident 4 between 28 March 2019 – 5 May 2019

32) Administered Syringe change 60ml to Resident 4 between 28 March 2019 – 5 May 2019

In relation to Resident 5

33) Administered Co-codamol 8mg/500mg tablets to Resident 5 between 28 March 2019 – 7 May 2019

34) Administered Clonazepam 0.5mg tablets to Resident 5 between 28 March 2019 – 7 May 2019

35) Administered Omeprazole 20mg to Resident 5 between 28 March 2019 – 7 May 2019

36) Administered Rivaroxaban 20mg tablets to Resident 5 between 28 March 2019 – 7 May 2019

37) Administered Flucloxacillin 500mg to Resident 5 between 28 April 2019 – 3 May 2019

38) Administered Otex Ear Drops to Resident 5 between 28 April 2019 – 7 May 2019

In relation to Resident 6

39) Administered Trapentadol MR 100mg tablets to Resident 6 between 28 March 2019 – 7 May 2019

40) Administered Baclofen 10mg tablets to Resident 6 between 28 March 2019 – 7 May 2019

41) Administered Co-codamol 30mg/500mg to Resident 6 between 28 March 2019 –7 May 2019

42) Administered Colecal440u+Calcium carb 1.25g to Resident 6 between 28 March 2019 – 7 May 2019

43) Administered Dantrolene 25mg to Resident 6 between 28 March 2019 – 7 May 2019

44) Administered Gabapentin 300mg to Resident 6 between 28 March 2019 – 7 May 2019

45) Administered Ranitidine 150mg tablets to Resident 6 between 28 March 2019 – 7 May 2019

46) Administered Chloramphenicol 0.5% eye drops to Resident 6 between 20 April 2019 – 7 May 2019.

Decision and reasons on the NMC application to amend the charges

The panel heard an application made by Mr Kennedy to amend the stem of charge 1 and a word within charge 1b.

Mr Kennedy submitted that the amendments refer to the stem of charge 1, to add 't' to correct a typographical error for "table" and at charge 1b to replace "during 18:00-18:30" with "between 18:00 -18:30". He submitted that is to correct the typographical error and clarify and better reflect the nature of the charges.

Current stem to charge 1 and 1b :

a) "On 6 January 2019 in relation to Resident A's Calcichew table;

    a) …

    b) Incorrectly completed Resident A's MAR Chart to indicate that you had administered the medication during 18:00 -18:30 as prescribed."

Proposed amendment to stem of charge 1 and 1b:

1) "On 6 January 2019 in relation to Resident A's Calcichew tablet;

    a) …

    b) Incorrectly completed Resident A's MAR Chart to indicate that you had administered the medication between 18:00 -18:30 as prescribed."

Mr Kennedy submitted that the proposed amendment would not cause any unfairness or injustice to Mr Yaji. He submitted that the nature of the proposed change does not alter the meaning of the charges that were sent to Mr Yaji.

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

> *28.—(1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—*
>
> *(a) the charge set out in the notice of hearing; or*
>
> *(b) the facts set out in the charge, on which the allegation is based,*
>
> *unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> *(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.*

The considered the merits of the case and whether any unfairness would result if the amendment to the charges were made.

The panel noted that the proposed amendments were correcting a typographical error and a stylistic change, and was solely for the purpose of clarity. The panel therefore accepted the two amendments, considered it being fair to make them and there being no injustice to either party as a result.

Decision and reasons on the NMC's application to admit written statement

The panel heard an application made by Mr Kennedy under Rule 31 to allow the written statement of Ms 9 into evidence. He submitted that the content of Ms 9's witness statement was relevant and speaks to part of charge 2 and aspects of charges 4, 5 and 6. He submitted that the statement itself is factual. He submitted that although Ms 9 was

available to provide evidence, she was not able to do so until Thursday afternoon and therefore there is a real possibility that this case may not conclude during its scheduled time period. He reminded the panel of the need for expeditious disposal of cases and given the nature of Ms 9's statement which is of a factual nature, not hearing her evidence live and admitting her witness statement will not cause any prejudice to Mr Yaji or this case.

In the preparation of this hearing, the NMC had included Ms 9's exhibits in the Case Management Form (CMF) sent to Mr Yaji on 17 April 2020. He reminded the panel that within the CMF there is a section to fill and return back with any objections to the documents being before the panel. Mr Yaji had not returned the CMF and to that extent he has not challenged the contents of the documents. On this basis Mr Kennedy advanced the argument that there was no lack of fairness to Mr Yaji in allowing Ms 9's written statement and associated documents into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 of the Rules provides that, so far as it is 'fair and relevant,' a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also referred the panel to the relevant considerations as set out in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

The panel noted that Ms 9'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 her. The contents of the statement were clearly relevant to some of the charges under consideration namely charges 2 to 7.

The panel considered whether Mr Yaji would be disadvantaged by the change in the NMC's position of moving from reliance upon the oral testimony of Ms 9 to that of a written statement.

The panel considered that as Mr Yaji had been provided with a copy of Ms 9's exhibits and, as the panel had already determined that Mr Yaji had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. The panel considered that Ms 9's witness statement and associated documents were relevant. They were also not the sole or decisive evidence as it is corroborated by other witnesses and the documents were hand-written notes which were written contemporaneously at or near the time of the incidents; and therefore were also consistent with her own statement. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel therefore determined that it would cause no prejudice to Mr Yaji to permit this evidence to be given in written form only. The panel would give what weight was appropriate to it once it had heard and evaluated the evidence before it and any submissions and advice, which it might be given.

Background

The NMC received a referral from Mr Yaji's former employer, Care UK Nursing & Residential Care Services regarding Mr Yaji's practice as a registered nurse following a number of incidents.

Mr Yaji was employed initially as a bank nurse at Station House Nursing Home Crew (the Home) and thereafter taken on as a full-time employee. The Home is a 71-bedded establishment with two units, one unit which provides care for residents needing general residential care and in a separate unit, providing care for patients with dementia (Coppenhall Unit). Mr Yaji was based in Coppenhall Unit.

The concerns date back to 2019 and related to a number of patients and their management and administration of medication, record keeping and signing of medication when not administered and associated dishonesty, not escalating and not completing documents appropriately.

Mr Yaji was suspended from duty pending the local investigation. During the investigation, he had resigned from his position and had not attended the disciplinary hearing. The Home had reported the incidents to the NMC as potentially amounting to professional misconduct.

Mr Yaji having left the Home, had obtained employment at Bramley Health, Croham Place, on 21 March 2019.

On 28 March 2019, Mr Yaji had been present and represented at an Interim Order hearing where the Investigating Committee imposed an Interim Conditions of Practice (ICOP) order on Mr Yaji's practice, which included restrictions on Mr Yaji's ability to administer medication unsupervised until such time as he was deemed competent to do so. Following the imposition of the order, Mr Yaji had failed to inform Bramley Health of his ICOP order.

Bramley Health had conducted a routine random check of nurses PIN's on 9 May 2019. It was only then that they had discovered that Mr Yaji had been subjected to an ICOP order. It is alleged that between 28 March 2019 and 9 May 2019, Mr Yaji had administered drugs, unsupervised, to a number of residents on a number of occasions.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Yaji.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Ms 1: Registered Manager at the Home;
- Ms 2: Deputy Home Manager at the Home;
- Ms 3: Daughter of Resident A;
- Mr 4: Manager at Croham Place (7 May 2019 - 2 September 2020);
- Dr 5 GP who does Ward rounds at the Home;
- Mr 6 Registered General Nurse at the Home;
- Mr 7 Registered Home Manager at Croham Place;
- Mr 8 Clinical Lead Nurse at Croham Place.

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 reached the following conclusions:

Ms 1: The panel considered the evidence of Ms 1 to be credible and reliable. She was clear, consistent and provided comprehensive answers. Her evidence was based on the investigation she carried out with Mr Yaji. The panel found Ms 1 did her best to assist the panel.

Ms 2: The panel found Ms 2's evidence to be credible and reliable. The panel found that she relied on her statement for much of her evidence, but accepted that this may be due to the passage of time. Ms 2 was clear and consistent about what she could and could not remember. She was clinically informative and provided consistent evidence during her oral evidence. She tried to assist the panel to the best of her abilities.

Ms 3: The panel found Ms 3 to be clear and consistent. It was of the view that Ms 3 was a credible and reliable witness. The panel was of the view that she had good memory recall as she was clear in what, when and why things happened. She was able to provide the panel with particular details of the events, as she was present at the Home consistently during Resident A's care. She was candid about things she did and did not remember. She attempted to assist the panel to the best of her knowledge and belief.

Mr 4: The panel found Mr 4's evidence to be credible and reliable. It was of the view that he was clear when he could not recall events accurately. He attempted to assist the panel to the best of his knowledge and recall.

Dr 5: The panel found Dr 5 to be a credible and reliable witness. He was clear and straightforward in his answers. The panel found that Dr 5 was calm and collected when giving evidence. He told the panel that he photographed the Home diaries in

order to update his own clinical records. He had a good recall of the events and he tried to assist the panel to the best of his ability.

Mr 6: The panel found Mr 6 to be a clear, credible and reliable witness. The panel found his evidence to be helpful. He provided the panel with clear evidence about the different types of documentation and their importance. He was clinically informative and provided consistent evidence during his oral evidence. He tried to assist the panel to the best of his ability.

Mr 7: The panel considered the evidence of Mr 7 to be credible and reliable. He had a good memory recall of events and he provided the panel with details of the internal processes. The panel found that he was able to provide it with comprehensive answers and was illuminating about a number of matters, which greatly assisted the panel. The panel formed the view that he demonstrated a good knowledge in his area of work and provided factual answers.

Mr 8: The panel found Mr 8 to be a straightforward and credible witness. He provided consistent responses. His answers to the panel were concise and reliable. His evidence was objective and unbiased. The panel found his evidence to be fair and he was a professional witness who attempted to assist the panel to the best of his knowledge and recall.

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

Charge 1a and 1b

That you, a registered nurse, whilst employed at Station House Nursing Home;

1) On 6 January 2019 in relation to Resident A's Calcichew tablet;

a) Did not administer a Calcichew tablet to Resident A between 18:00-18:30 as prescribed.
b) Incorrectly completed Resident A's MAR Chart to indicate that you had administered the medication between 18:00 -18:30 as prescribed.

These sub-charges are found NOT proved.

In reaching this decision, the panel accepted all the evidence in relation to Resident A and Resident A's medical documentation.

The panel noted that there has been no evidence presented to it of this medication being prescribed to Resident A or prescribed to be taken between 18:00 - 18:30. The panel was of the view that in the absence of such a MAR chart or prescription, it could not reasonably infer that the prescription required the tablet to be administered between 18:00 - 18:30.

For the same reason, the panel concluded that there was no evidence to show that the prescription required the tablet to be administered between 18:00 -18:30.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and, therefore, in the absence of a MAR chart for Resident A confirming such a prescription, on the balance of probabilities, the panel found charge 1a and 1b not proved.

Charge 1c

That you, a registered nurse, whilst employed at Station House Nursing Home;

1) On 6 January 2019 in relation to Resident A's Calcichew tablet;

c) Did not administer a Calcichew tablet to Resident A until after approximately 19:40.

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Ms 3, Ms 1 and the Home's internal meeting minutes dated 18 January 2019.

The panel noted that Ms 3's written witness statement dated 2 September 2019, which was consistent with her oral evidence, stated:

> '*…I was just waiting for her medication to be given by the Nurse, and for her to be repositioned and to have personal care for the evening. However, the medication did not come at all at 18:00. A nurse normally goes round the Home with the medication trolley between 18:00 and 18:30 but the Nurse did not arrive to see my mum at all. I waited for a bit longer as I understand things can get a bit busy at the Home and run out schedule. But when the time got to 19:40, I was really concerned and I did not think the Nurse was coming so I had to go and ask him.*
> […]
> *I eventually had to ask the male nurse. I can confirm that this was the registrant. When I asked him for my mum's medication, I saw him go to the medication office where they keep the tablets locked up, he unlocked got the medication and administered it* […]'

The panel noted through Ms 3's oral evidence that she was aware of the usual times the medication was provided to Resident A as she was a regular visitor.

The panel also had sight of the meeting minutes, dated 18 January 2019, in which it notes the meeting record between Ms 1 and Mr Yaji. The panel noted that Mr Yaji did not deny this position and stated that:

> '*The medications were taking a long time and so that might be why* […] *I don't know why it was a while ago and I do the important medications first.*'

Ms 1, in her written witness statement dated 11 October 2019 stated:

> '[…] *regarding Resident A's daughter coming round and asking for the Calcichew* […] *I note* [Mr Yaji] *said, "The medications were taking a long time and so that might be why" and when I asked him why it was so late why it had been forgotten"* [sic]*, he said, "I don't know why it was a while ago and I do the important medications first". He did not say anything to me that would explain why he missed the medication.*'

In light of the above evidence, the panel found charge 1c, that on 6 January 2019 in relation to Resident A, Mr Yaji did not administer a Calcichew tablet to Resident A until after approximately 19:40.

Accordingly, the panel found charge 1c proved.

Charge 2a, 2b and 2d

That you, a registered nurse, whilst employed at Station House Nursing Home;

2) On 7 January 2019 in relation to Resident B, you;

   a) Incorrectly opened a pain relieving patch.
   b) Did not immediately administer/place the patch on Resident B.
   d) Did not destroy the patch

These sub-charges are found proved.

In reaching this decision, the panel accepted the evidence of Ms 1, Ms 2, Ms 9 and the undated Medication Audit report for Coppenhall which follows the Audit dated 4 January

2019.

The panel noted Ms 1's written witness statement dated 11 October 2019 in which she said:

> '*I was also concerned to find out he had signed the CD book to say he had administered the resident's CD pain patch and he dated it 7 January 2019 but he did not use or apply the patch to the resident. He said he opened it in error but he should have destroyed it. She did get a pain patch in the end, it was just that he inappropriately opened the patch when he needn't have opened it as you just apply the patch to the resident only when ready to do so. Once the patch is opened, it cannot be used other than applying to that resident, it loses its prominence, and it is no longer useful. He should have destroyed it- but he just opened it and date it.*' [sic]

The panel also noted that Ms 2 corroborated Ms 1's evidence above in her oral and written evidence. In Ms 2's written witness statement dated 11 October 2019, Ms 2 states:

> '*I was also concerned to find out he had signed the Home's CD book to say he had administered Resident B's CD pain patch and he dated it 7 January 2019 but he did not use or apply the patch to the resident. This was not picked up by me and I did not do the QDM audit concerning this but I can confirm he did not comply with the Home's medication administration policy.*'

The panel also had sight of the undated Medication Audit report for Coppenhall which follows the Audit dated 4 January 2019, in which it stated under Resident B:

> '*Butec patch opened and dated in the CD cupboard – need to dispose of and reorder.*'

The panel further noted Ms 9's written witness statement, dated 11 October 2019, states:

'*I was also concerned he had signed the CD book to say he had administered the resident's CD pain patch and he dated it 7 January 2019 but he did not use or apply the patch to the resident. She did get a pain patch in the end, it was just that he inappropriately opened the patch when he needn't have opened it as you just apply the patch to the resident only when ready to do so. Once the patch is opened, it cannot be used other than applying that resident. It loses its prominence, and is no longer useful. He should have destroyed it – but he just opened and dated it.*'

In light of the above evidence, the panel found that on 7 January 2019 in relation to Resident B, Mr Yaji incorrectly opened a pain relieving patch, did not immediately administer/place the patch on Resident B and he did not destroy the patch.

Accordingly, the panel found charges 2a, 2b and 2d proved.

Charge 2c

That you, a registered nurse, whilst employed at Station House Nursing Home;

2) On 7 January 2019 in relation to Resident B, you;

c) Incorrectly signed the Controlled Drug Book indicating that the patch had been administered.

This charge is found NOT proved.

In reaching this decision, the panel accepted the evidence of Ms 1 and Ms 2.

The panel bore in mind that it did not have before it Resident B's entry in the Controlled Drug Book. In these circumstances the panel had no direct information to suggest that Mr Yaji had incorrectly signed the Controlled Drug Book.

The panel considered the evidence of Ms 1 and Ms 2. Both Ms 1 and Ms 2 had stated in their written witness statements that they were concerned that Resident B's entry in the Controlled Drug Book had been signed by Mr Yaji to state that he had administered Resident B their pain patch and had dated it 7 January 2019.

However, during her oral evidence, Ms 1 said Mr Yaji had not signed the Controlled Drug Book. Ms 2 however stated she was 'almost certain' that Mr Yaji had incorrectly signed the Controlled Drug Book.

In these circumstances, due to the fact that the panel did not have sight of the Controlled Drug Book and having contradictory oral evidence from Ms 1 and Ms 2, it could not be satisfied that on 7 January 2019 in relation to Resident B, Mr Yaji incorrectly signed the Controlled Drug Book indicating that the patch had been administered to Resident B.

Accordingly, the panel found charge 2c not proved.

Charge 3

That you, a registered nurse, whilst employed at Station House Nursing Home;

3) You actions in charge 2 c) above were dishonest in that you knew you had not administered the patch to Resident B, but sought to represent that you had.

This charge is found NOT proved.

Since charge 2c is not proved, this charge cannot be proved.

Charge 4

That you, a registered nurse, whilst employed at Station House Nursing Home;

4) On 7 January 2019 after being instructed to dispose of Resident B's Oramorph, you;

a) Did not dispose of the Oramorph;
b) Did not remove the Oramorph from the drug cupboard.

This charge is found proved in its entirety.

In reaching this decision, the panel accepted the evidence of Ms 9, the Home's internal meeting minutes dated 18 January 2019 and the undated Medication Audit report for Coppenhall which follows the Audit dated 4 January 2019.

The panel further noted Ms 9's written witness statement dated 11 October 2019 states:

'*I can confirm that on 7 January 2019* […] *the Quality Development Manager, who is a nurse – told the registrant – in my presence – not to give Resident B their oramorph medication as it was out of date…He was verbally told by* [the Quality Development Manager] *to destroy their medication and re-order a new stock to arrive that same day. However, he did not do this* […]

It was our Team Leader […] *who told me she was concerned* [Mr Yaji] *was considering giving the out of date oramorph to Resident B. When* [the Quality Development Manager] *and I went to the treatment room I saw him holding the bottle ready to give it to her. He was asking me "how does it only have 3 month shelf life" and "where does it say that" and I pointed it out on the box and then he said "what am I supposed to give then?" which is inappropriate…*'

The panel also had sight of the undated Medication Audit report for Coppenhall which follows the Audit dated 4 January 2019, in which it stated under Resident B:

> '*Oramorph opened and in CD cupboard – dated 2.10.18 – out of date – need to dispose of and order more.*'

The panel further noted that in the Home's internal meetings minutes, dated 18 January 2019, when questioned regarding the out of date Oramorph, Mr Yaji said:

> '*I was not going to give this I even pointed this out* […] *I was not going to give this as it was out of date.*'

Mr Yaji does not face an allegation that he intended to administer this Oramorph, but allegations that he did not dispose of the Oramorph and did not remove it from the Drug cupboard.

The panel accepts the evidence of Ms 9 and finds that on 7 January 2019, after being instructed to dispose of Resident B's Oramorph, Mr Yaji did not dispose of the medicine nor remove the Oramorph from the drug cupboard.

Accordingly, the panel found charge 4 in its entirety proved.

Charge 5a and 5b

That you, a registered nurse, whilst employed at Station House Nursing Home;

5) On 14 January 2019;

   a) Did not take a swab of Resident C's toe.
   b) Did not complete the Unit diary stating that you had not taken a swab of Resident C's toe.

These sub-charges are found proved.

In reaching this decision, the panel accepted the contents of the Home's internal meeting minutes dated 18 January 2019, the evidence of Ms 1, Ms 2 and Ms 9.

The panel noted that the Home's internal meetings minutes dated 18 January 2019, regarding Resident C's toe:

> '[Bed manager] […] *Why did you not swab this?*
> [Mr Yaji] *There was nothing to swab it was dry…I did handover, there was no reasons for me to swab this as it was dry."*

The panel noted Ms 1's written witness statement, dated 11 October 2019, in which she states:

> '*Resident C had a toe which was quite necrotic. He was supposed to have taken a swab of her toe on 14 January 2019.*'

The panel also noted Ms 2's written witness statement, dated 11 October 2019, in which she states:

> *I can confirm that on 14 January 2019 the registrant also failed to take and store a swab of Resident C infected toe in the fridge - as I had requested him to do… He needed to take swabs on that day as it was too late to get it to the Path lab so we needed a swab to be taken and put in the specimen fridge* […]'

The panel further noted Ms 9's written witness statement dated 11 October 2019, in which she states:

'*On 14 January 2019* [Mr Yaji] *had approached me with a swab asking me if it could go in the fridge to be sent tomorrow as no member of staff was available to drive the swab to the lab. It was only when I read his care plan that I realised it had not been done – as he had written there "swab required" rather than "taken". I took this to mean he was saying someone else needed to do the swab as he had not done it as requested. But he did not put in the diary he had not done the swab and that it still needed to be done.*'

The panel was satisfied that there was clear evidence before it to conclude that Mr Yaji did not take the swab of Resident C's toe nor complete the Unit diary stating that he had not taken a swab of Resident C's toe.

Accordingly, the panel found charges 5a and 5b proved.

Charge 5c

That you, a registered nurse, whilst employed at Station House Nursing Home;

5) On 14 January 2019;

c) Did not handover information that you had not taken a swab of Resident C's toe.

This charge is found NOT proved.

In reaching this decision, the panel accepted the contents of Resident C's care plan, the evidence of Ms 1 and Ms 9.

The panel read Ms 1's witness statement dated 11 October 2019, in which she states:

'[…] [Ms 9] *could not find the swab to send on 15 January 2019 the next day. It was not until she read his care plan that she realised it had not been done – he had written "swab to be taken" but he did not put in the diary he had not done the swab and it needed to be done.*'

The panel also noted Ms 9's written witness statement, dated 11 October 2019, in which she states:

'*It was only when I read his care plan that I realised it had not been done – as he had written there "swab required" rather than "taken". I took this to mean he was saying someone else needed to do the swab as he had not done it as requested.*'

The panel noted that Ms 9's statement is also confirmed in her contemporaneous handwritten notes.

The panel appreciated from the evidence before it that Mr Yaji had not complied with the systems and processes in the Home, which would have alerted staff in the correct places to the fact that a swab of Resident C's toe had not been done. However, the panel was satisfied, from the wording of the facts of this incident as charged, Mr Yaji's notes in the care plan was a handover of information regarding Resident C's toe.

In these circumstances, the panel found charge 5c not proved.

Charge 6a

That you, a registered nurse, whilst employed at Station House Nursing Home;

6) On 14 January 2019 following Resident D suffering a fall;

a) Did not inform Doctor 1 to examine/review Resident D

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Dr 5, Ms 1, Ms 2 and Ms 9.

The panel reminded itself of Dr 5's oral evidence where he was emphatic on the point that he was not informed to examine/review Resident D. The panel also had regard to Dr 5's written witness statement dated 29 August 2019 in which he stated:

> '*I can confirm that I did not visit Resident D on 14 January 2019 the day in question, as she was not on the list* […]
>
> *I can confirm that on 14 January 2019 the registrant never consulted me about Resident D having a fall. I had no conversation with the registrant and I did not hear from him.*
>
> […]
>
> *I am concerned that the registrant had not informed me during my visit on 14 January 2019 – my understanding was that he knew that she had had a fall at that time."*

The panel read Ms 2's witness statement dated 11 October 2019, in which she states:

> '*I can confirm that the main incident I was concerned with was on 14 January 2019- when the registrant failed to advise* [Dr 5] *that Resident D had had a fall that day and needed to be examined then, as I had instructed the registrant to do so… "Later on that day I was on the Unit (I am not sure what time) but this was before the GP visit which took place between 12 noon and 2pm. I saw* [Ms Yaji] *and I asked him, "How was the lady who had fallen? He said he himself had checked her over and that he was not concerned. I asked the GP to review her.*'

The panel was satisfied that Ms 2 provides direct evidence to Resident D's fall. Furthermore, the panel had sight of Ms 2's contemporaneous handwritten notes dated 15 January 2019, which again confirms Resident D's fall.

The panel read Ms 1's witness statement, dated 11 October 2019, in which she states:

> '[…] *Following day, however on 15 January 2019, when the registrant was not on shift, the resident was not presenting well and we got in touch with* [Dr 5]*. He came round and said that he had not been asked by the registrant to see her on 14 January 201 when he was round and so he did not see her that day. We knew the doctor has not seen her as he had not recorded seeing her in the patient's notes. He definitely had not seen her on 14 January 2019.*'

The panel also noted Ms 9's witness statement dated 11 October 2019 in which she confirmed that Resident D had had a fall. She stated:

> '*I can confirm that on 14 January 2019, following Resident D's fall (which I did not see), I heard [Ms 2] speak with the registrant and ask him to make sure [Dr 5] had reviewed Resident D - as the GP was at the Home doing his round on that day.*'

Taking all of the above into account, the panel finds that on 14 January 2019 following Resident D's fall, Mr Yaji did not inform Dr 5 to examine/review Resident D.

In these circumstances, the panel found charge 6a proved.

Charge 6b

That you, a registered nurse, whilst employed at Station House Nursing Home;

6) On 14 January 2019 following Resident D suffering a fall;

b) Did not write in the GP/Unit diary that Doctor 1 had been asked and/or reviewed Resident D.

This charge is found proved.

In reaching this decision, the panel accepted the copy of the diary which showed no entry in relation to Resident D and accepted the evidence of Dr 5.

In light of the absence of any such entry, the panel finds charge 6b proved.

Charge 6c, 6d, 6e and 6f

That you, a registered nurse, whilst employed at Station House Nursing Home;

6) On 14 January 2019 following Resident D suffering a fall;

c) Did not update the MFRA
d) Did not complete a body map
e) Did not complete a 72 hours post fall form
f) Did not update Resident D's mobility care plan

These sub-charges are found proved.

In reaching this decision, the panel took accepted the evidence of Mr 6.

The panel reminded itself that Mr 6 categorically said during his oral evidence that he was the hand-over nurse for the night shift and that the Monthly Risk Factor Assessment (MRFA), complete body map, 72 hours post fall form and an update of Resident D's mobility care plan should have been updated but was not done so. The panel noted that this evidence was consistent with what was written in his witness statement dated 5 February 2021.

The panel noted that Mr 6 in his witness statement had provided detailed explanations of the importance of each document and the need for them to be accurately and appropriately updated and the fact that Mr Yaji had not updated or completed these.

The panel found Mr 6 to be a credible and reliable witness.

In these circumstances, the panel found charge 6c, 6d, 6e and 6f proved.

Charge 6g and 6h

That you, a registered nurse, whilst employed at Station House Nursing Home;

6) On 14 January 2019 following Resident D suffering a fall;

g) Incorrectly informed the Deputy Manager Colleague 1, that Doctor 1 had reviewed/examined Resident D.
h) Incorrectly informed Deputy Manager Colleague 1 that Doctor 1 had "no concerns" with Resident D.

These sub-charges are found proved.

In reaching this decision, the panel accepted the evidence of Dr 5 and Ms 2.

The panel noted that Dr 5 was very clear throughout his oral and written evidence that he was not asked to see Resident D on 14 January 2019.

The panel also had regard to Dr 5's written witness statement, dated 29 August 2019, in which he stated:

> '*I can confirm that on 14 January 2019 the registrant never consulted me about Resident D having fall. I had no conversation with the registrant and I did not hear from him* […] *I did not tell him that I was "not concerned" about Resident D, He did not tell me* […] *I understand he said I had seen him when I had not* […] *I only learnt of the resident having a fall the day after, on 15 January 2019 when the Home noted the resident had not been seen by me.*'

The panel also had sight of Ms 2's witness statement, dated 11 October 2019, in which she states:

> '*Later on at 14:00 he was dishonest. When I asked him if the GP had "seen her" when he told me the GP had seen her, Yes" and that the GP was not concerned about her,* [Ms 9] *unit manager was with me when I asked him this and she witnessed his reply. He said he had assessed the patient, done physical checks and observations. The resident had had a fall and it concerned me that he did not act to get the GP to check her and get a medical opinion* […]'

The panel was satisfied that there was clear evidence before it to conclude that Mr Yaji did incorrectly inform the Deputy Manager that the doctor had reviewed/examined Resident D and that the doctor had no concerns with Resident D.

Accordingly, the panel found charges 6g and 6h proved.

Charge 7

That you, a registered nurse, whilst employed at Station House Nursing Home;

7) Your actions in charge 6 g) & h) were dishonest in that you knew that Doctor 1 had not examined/reviewed Resident D, but you sought to represent that he had

This charge is found proved.

In reaching this decision, the panel took into account its decision and reasons in relation to charges 6g and 6h.

The panel had clear evidence from Ms 2 that when she had asked Mr Yaji whether the GP had seen Resident D, Mr Yaji had told her *'Yes and that the GP was not concerned about her.'*

The panel was of the view that Mr Yaji having not alerted the doctor to see Resident D would have known full well that the Doctor had not gone to see resident D nor conducted any examinations on her. Therefore, Mr Yaji provided incorrect and untrue information to the Deputy Manager. The panel was of the view that an ordinary decent person would consider Mr Yaji's actions to be dishonest.

In these circumstances, the panel found charge 7 proved.

Charge 8

That you, a registered nurse, whilst employed by Bramley Health (the Employer) at Croham Place between 21 March 2019 & 9 May 2019;

8) Did not comply with paragraph 10 a) of the Interim Conditions of Practice Order imposed on 28 March 2019 by an Investigating Committee of the NMC, in that you;

a) Between 28 March 2019 & 9 May 2019 did not disclose to your employer that you were subject to an Interim Conditions of Practice Order.

This charge is found proved.

In reaching this decision, the panel accepted the contents of the letter, which includes the Interim Conditions of Practice Order dated 29 March 2019, and the evidence of Mr 7.

The panel first had sight of the letter dated 29 March 2019 addressed to Mr Yaji which included the interim conditions of practice order imposed on his practice and the determination of the interim order. The panel noted that Mr Yaji had been present and represented at that hearing. Therefore the panel had no doubt as to his awareness regarding these restrictions.

The panel further noted the evidence of Mr 7. In answer to a question during his oral evidence as to whether Mr Yaji had disclosed his interim conditions of practice order to Mr 7, Mr 7 replied, '*he didn't*'.

The panel also noted Mr 7's witness statement, dated 17 September 2019, in which he stated:

'*Mr Emmanuel Yaji commenced employment on 21 March 2019. I was his line manager. I had a good working relationship with him. That's why I was completely surprised when it came out that I saw he failed to disclose to me as his employer that he is obliged to meet certain specific criteria/interim conditions of practice as part of his registrations as specified at a hearing on 28th March 2019*

[…]

Our HR team do spot checks on NMC Pins and they checked Emmanuel's name on the NMC website. They flagged it with me straight away on 9 May 2019 that he was subject to interim conditions of practice and I met with him

[…]

I showed him the conditions on the NMC website and went through. I said "Are you aware?" as he was clearly at the hearing and had representation. He apologised and admitted he needed to disclose the conditions.'

Having found Mr 7 to be a credible witness and having had sight of the conditions of practice order and Mr Yaji's own admission to Mr 7 at the time, the panel was satisfied that Mr Yaji had not complied with paragraph 10 a) of the Interim Conditions of Practice Order imposed on 28 March 2019 by an Investigating Committee of the NMC, in that; between 28 March 2019 & 9 May 2019, Mr Yaji did not disclose to his employer that he was subject to an Interim Conditions of Practice Order.

In light of the above evidence, the panel found charge 8 proved.

Charge 9

That you, a registered nurse, whilst employed by Bramley Health (the Employer) at Croham Place between 21 March 2019 & 9 May 2019;

9) Did not comply with paragraph 2 a) of the Interim Conditions of Practice Order imposed on 28 March 2019 by an Investigating Committee of the NMC, in that you;

a) On one or more occasion between 28 March 2019 & 9 May 2019 administered medication to Residents unsupervised, as listed in schedule 1.

This charge is found proved.

Before considering this charge, the panel noted that in respect of the 20th entry in schedule 1, the MAR chart in relation to this date and in respect of this resident, gives 15 mg rather than 16mg.

In reaching this decision, the panel accepted the contents of the letter which includes the Interim Conditions of Practice Order dated 29 March 2019, and the evidence of Mr 8.

The panel had sight of the conditions of practice order and it paid particular attention to condition 2a in which it states that:

'*You must not administer medication other than under direct supervision until you are assessed as competent to do so by another registered nurse where you are working at the time.*'

The panel was of the view that condition 2a makes it very clear to anyone reading it, that Mr Yaji was subject to direct supervision and as he was presented and represented at the

hearing and therefore he could not have been in any doubt about what was required of him.

The panel further noted that the entirety of Mr 8's evidence was corroborated by every instance in schedule 1 on at least one occasion.

It noted that Mr 8, in his written witness statement, dated 15 April 2021, states:

> '*I can confirm the registrant was administering medication without supervision during the period of his employment in Croham Place.*'

The panel had sight of MAR charts from the beginning till the end of Mr Yaji's employment which shows medication was administered to patients whilst he was unsupervised.

The panel accepted Mr 8's evidence and having had sight of the conditions of practice order, particularly condition 2a and the MAR charts in which it is shown that Mr Yaji has administered medication unsupervised, the panel was satisfied that this charge is found proved.

Charge 10

That you, a registered nurse, whilst employed by Bramley Health (the Employer) at Croham Place between 21 March 2019 & 9 May 2019;

10) Your actions in charges 8 and/or 9 were dishonest, in that you sought to conceal, that regulatory restrictions were placed upon your practice, from Bramley Health.

This charge is found proved

In reaching this decision, the panel accepted the contents of the letter, which includes the Interim Conditions of Practice Order, dated 29 March 2019, and its decision and reason in relation to charges 8 and 9. The panel had already determined that charge 8 and 9 are proved.

The panel was of the view that Mr Yaji would have been well aware of what was required of him as he was present and represented at the Interim Order hearing. Further, the panel concluded that the interim conditions provided no ambiguity in relation to the meaning of the charges.

The panel had regard to Mr 8's written witness statement, dated 17 September 2019, in which he states:

> '[Mr Yaji] *apologised and admitted he needed to disclose the conditions* […] *In relation to his reason for non-disclosure, he just apologised to me and said he didn't tell us.*'

In these circumstances, the panel was satisfied that Mr Yaji, whilst employed by Bramley Health at Croham Place between 21 March 2019 & 9 May 2019; was dishonest, in that he sought to conceal, that regulatory restrictions were placed upon his practice, from Bramley Health.

Accordingly, the panel found charge 10 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 Mr Yaji'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, Mr Yaji's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

In his submissions Mr Kennedy invited the panel to take the view that Mr Yaji's actions amounted to a breach of *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)* (the Code). He then directed the panel to specific paragraphs and identified where, in the NMC's view, Mr Yaji's actions amounted to misconduct.

He submitted that Mr Yaji did not adhere to straightforward medication practices in relation the Resident B's drugs. His failure to carry out simple instructions in relation to Resident C and Resident D led to a delay in their treatment, which consequently caused harm. He submitted that the failure in respect of Resident D was exacerbated by Mr Yaji's dishonesty in telling his colleagues that the resident had been seen by the doctor.

Furthermore, his further ‘lie’ about his interim conditions of practice order to his new employer was also serious. Mr Kennedy reminded the panel that Mr Yaji administered medication whilst at his new employment for approximately two and half months which was in direct contravention of one of his interim conditions imposed on his practice, thereby putting patients at risk of harm. Mr Kennedy therefore submitted that such behaviour fell far below the standard expected of a registered nurse and amounted to misconduct.

He then 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. Mr Kennedy referred the panel to the cases of *CHRE v (1) NMC (2) Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

Mr Kennedy submitted that through Mr Yaji’s actions, he put others at an unwarranted risk of harm. He further submitted that Mr Yaji, through his actions brought the profession into disrepute and contravened the expectation of a registered nurse. He submitted that Mr Yaji breached fundamental tenets of the profession.

He reminded the panel that Mr Yaji has not shown any insight. He has not fully participated in the investigation at the Home and as he was summarily dismissed from Bramley Health, he did not get the opportunity to demonstrate any insight. Mr Kennedy submitted that had Mr Yaji’s ICOP not been discovered, he would have carried on working and administering medication in contravention of his conditions. He has not participated in these NMC proceedings and therefore the panel has no information of any insight before it.

He also submitted that dishonesty was engaged in this case. Mr Yaji’s misconduct raises questions about the extent to which he can be trusted to communicate appropriately and effectively. Mr Kennedy reminded the panel that patients, their relatives, colleagues and

employers need to have confidence in staff. Mr Kennedy submitted that Mr Yaji's behaviour, as at 2019 has had an adverse impact on that trust. His dishonesty caused patient harm at the Home and his lies of omission at Crohem Place also affected the reputation of the profession. He submitted that there is no information of his current employment and nothing to suggest that he can now be trusted to perform nursing duties to the required standards in an honest and straightforward manner. He submitted that in relation to remediation, there have been no errors in Mr Yaji's practice other than the fact that he should have not been doing it unsupervised. He submitted that the dishonesty in this case demonstrates an attitudinal problem. He reminded the panel that due to the lack of remediation regarding his dishonest conduct, there is a risk of repetition. In these circumstances, Mr Kennedy submitted that Mr Yaji's practice is impaired on both public protection and public interest grounds.

The panel heard and accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons 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.'*

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

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

‘*1.2 make sure you deliver the fundamentals of care effectively*

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

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

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

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

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body."

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered them individually and collectively. It took account of all the evidence before it and the circumstances of the case as a whole.

The panel was of the view that, in this case, charges 1, 2, 4 and 5 in isolation would be regarded as poor practice rather than misconduct. However, cumulatively in respect of these charges, it was of the view that Mr Yaji's conduct fell seriously short of the standards expected of a registered nurse. It was of the view that his actions demonstrated a pattern of behaviour and the similarities of the failings amounted to serious misconduct.

The panel reminded itself that Mr Yaji's failure to carry out simple instructions in relation to Resident C and Resident D led to delay in their treatment and therefore not only caused unwarranted risk of harm but actual patient harm. Furthermore, Resident D's concerns were exacerbated by Mr Yaji's dishonesty in telling his colleagues that the resident had been seen by the doctor when he had not.

Honesty and integrity are the bedrocks of the nursing profession. The panel considered that Mr Yaji was under a clear obligation to disclose this information to any prospective employer regarding his interim conditions of practice order. Despite this, between 28 March 2019 and 9 May 2019 he dishonestly withheld this important information from his employer which he was required to give them. The panel considered that such actions would be considered deplorable by fellow members of the nursing profession and were sufficiently serious to amount to misconduct.

In these circumstances, the panel found that Mr Yaji's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Yaji'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, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel found that all four limbs of *Grant* were engaged in this case. By failing to carry out instructions regarding medications administration, failing to properly store and remove drugs and by not asking the doctor to see the relevant resident as advised by his senior, Mr Yaji placed residents, as well the public, at unwarranted risk of harm and brought the nursing profession into disrepute. He also breached fundamental tenets of the profession.

Furthermore, the requirement that an interim conditions of practice order is disclosed to current or prospective employers is to safeguard patient safety. Similarly, employees are asked to disclose their professional registration details so that employers can check that they are suitably qualified and safe to practise. The panel considered that by failing to disclose Mr Yaji's NMC interim conditions of practice order, he could have placed patients at unwarranted risk of harm by administering medication unsupervised in direct contravention of his interim conditions. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel took account of the two undated reflective accounts that were produced during earlier performance management at the Home. In addition, the panel considered that there were some acknowledgements of his failings when confronted by his senior manager at Bramley Health. The panel determined that the insight demonstrated by Mr Yaji is extremely limited.

In relation to remediation, the panel determined that the misconduct found in this case is remediable. However, it has had no information from Mr Yaji demonstrating any such remediation. Mr Yaji has not engaged with these NMC proceedings. He has not informed the panel or the NMC of his current practice.

The panel determined that Mr Yaji did not and has not yet grasped the significance of the concerns raised regarding his practice or the potential consequences those concerns could have upon patients in his care. As of today's date, the panel have no evidence before it that Mr Yaji has undertaken training to address the concerns raised or reflected upon his failings.

In the absence of any proper insight and remediation into the misconduct found proved, the panel determined that there is a high risk that the misconduct could be repeated. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession. The panel determined that, in this case, a finding of impairment on public interest grounds was required. A member of the public must be able to trust that nurses can carry out basic nursing duties and follow simple instructions.

Having regard to all of the above, the panel was satisfied that Mr Yaji'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 Mr Yaji off the register. The effect of this order is that the NMC register will show that Mr Yaji 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 Kennedy referred the panel to the SG and he drew the panel to what the NMC thought to be the aggravating and mitigating features of the case. He submitted that the appropriate sanction in this case is a striking-off order. Mr Kennedy submitted that Mr Yaji's behaviour and underlying charges are too serious for no further action or a caution order. He submitted that the concerns cannot be addressed by a conditions of practice order. He submitted that given the facts of this case, a striking-off order would protect public confidence and professional standards. He submitted that Mr Yaji's actions demonstrate a fundamental incompatibility with being a registered professional and raises serious concerns about his deliberate breach of the duty of candour. He submitted that the patients were vulnerable and Mr Yaji's dishonesty was deliberate and premeditated. He further submitted given the facts of this case, a striking-off order is the only appropriate sanction in this case in order to protect public confidence and professional standards. However, he submitted that this was a matter for the panel's professional judgment.

Decision and reasons on sanction

Having found Mr Yaji'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:

- Conduct which caused patients actual harm;
- Repeated dishonesty in relation to a patient and an employer;
- Lack of insight, remorse and remediation into failings;
- Deliberately flouted the interim conditions of practice order.

The panel determined it could not identify any mitigating factors in this case.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public interest issues identified, an order that does not restrict Mr Yaji'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 Mr Yaji'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 Mr Yaji's registration would be a sufficient and appropriate response. 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. The misconduct identified in this case was not something that can be addressed through retraining. In addition, Mr Yaji has been previously subject to an interim conditions of practice order which he failed to adhere to. The panel had no information before it to suggest he will comply with such an order. In any event, the panel concluded that the placing of conditions on Mr Yaji's registration would not adequately address the seriousness of this case and the associated dishonesty and it would not satisfy the public interest.

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;*

Mr Yaji's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. His misconduct was not a single incident but a number of incidents some of which resulted in actual patient harm; and also involved a prolonged period of deception relating to unsupervised administration of medication. The panel further noted that Mr Yaji had only returned to practice and re-registered as a nurse in 2018 and his first employment since his re-registration was at the Home. It noted that within this short space of time, Mr Yaji's professionalism was called into question. The panel further bore in mind that he deliberately breached his interim conditions of practice order, which his regulator imposed on him. It also regarded Mr Yaji's behaviour in deliberately disobeying an instruction to call the doctor and then lying to a colleague when specifically asked if he had done so, to be inexcusable. Through his actions, Mr Yaji abused the trust of colleagues and his employer through his dishonesty and has demonstrated little or no insight into his behaviour. The panel concluded that the serious nature of Mr Yaji's conduct was fundamentally incompatible with him 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?*

Mr Yaji's actions were significant departures from the standards expected of a registered nurse, and the panel is of the view that they are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Yaji's actions were serious and to allow him to practise would undermine public confidence in the profession and in the NMC as a regulatory body.

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. Given that Mr Yaji's actions had brought the profession into disrepute by adversely affecting the public's view of how registered nurses conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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.

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 Mr Yaji's own interest until the striking-off order takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that an interim suspension order for a period of 18 months would cover the 28 days before the striking-off order comes into effect, and the subsequent appeal period should Mr Yaji appeal the decision. He submitted that the grounds for this would mirror the panel's earlier decision, that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary 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 given the seriousness of the dishonesty and in

the interest of protecting the public and in maintaining public confidence in the nursing profession and the NMC as a regulator.

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

This will be confirmed to Mr Yaji in writing.

That concludes this determination.