Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 1 September – Wednesday 7 September 2022

Virtual Hearing

Name of registrant:	**Abiodun Folasade Adejumo**
NMC PIN:	03J0403O
Part(s) of the register:	Nursing – Sub Part 1 RN1: Adult Nurse, Level 1 (10 October 2003)
Relevant Location:	Edinburgh
Type of case:	Misconduct
Panel members:	Rachel Childs (Chair, Lay member) Louise Poley (Registrant member) Rosalyn Mloyi (Registrant member)
Legal Assessor:	Michael Bell
Hearings Coordinator:	Megan Winter
Nursing and Midwifery Council:	Represented by Michael Smalley, Case Presenter
Mrs Adejumo:	Present and represented by Andrew Mellor, Thompsons Solicitors
Facts proved by admission:	Charges 1, 2, 3a, 3b, 3c, 4, 6, 7a, 7b, 8a, 8b, 8c, 8e, 8f (i), 8f (ii), 8g, 8h (i), 8h (ii), 8h (iii), 8i, 8j, 8k, 8l, 8m, 8n, 8o, 8p, 8q, 8r, 8s, 9, 10, 11a, 11b and 12
Facts partly proved by admission:	Charges 5a, 5b, 5c, 5d in that you had not ensured that staff had consistently used the equipment required to care for service users
Facts proved:	Charge 5c in that you in that you had not ensured that staff had consistently used the equipment required to care for service users **AND** you had not ensured that staff were adequately trained in the equipment.

Facts not proved:	Charge 8d
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (36 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

That you, a registered nurse and registered manager of Standard Care Recruitment Limited ["Standard Care"]:

1) Failed to ensure Care Manager X was registered with the Scottish Social Services Council ["SSSC"] appropriate to his role within six months of commencing employment.

2) In around January 2018, failed to take any or any appropriate action on learning the Disclosure Scotland was considering including Care Manager X on their adult's list.

3) Did not ensure one or more service users' care plans and/or care records were of adequate quality, in that:

   a) On an unknown date, there was no care plan included within Service User B's care folder;

   b) On one or more unknown dates, carers attending Service User D did not record :

      i) The time their visit concluded,
      ii) What care had been provided,
      iii) When medication had been administered,
      iv) Their full names, only marking their initials;

   c) Service User D's records did not contain:
      i) Personal details for Service User D,
      ii) Emergency contact details,
      iii) Details of Service User D's GP,
      iv) Details of what needed to be completed on each visit.

4) Did not ensure adequate systems were in place to allow service users and/or their families to raise concerns about Standard Care directly with you.

5) Did not ensure staff were adequately trained to use and/or that they consistently used equipment required to care for service users, in that:

   a) On an unknown date in around October 2018, Service User B's catheter was left closed;

   b) On one or more occasions on unknown dates, carers pulled Service User B up by his armpits rather than using a hoist;

   c) On around 1 September 2018, Service User D's son had to teach carers how to use the bath seat as she had not been given a bath for around 10 days;

   d) On one or more occasion carers did not ensure Service User D was wearing her falls bracelet;

6) Did not ensure carers followed advice or instructions of medication professionals in that in around October 2018 Service User B was moved from his bed against the instructions of his Marie Curie Nurses.

7) On or around 25 October 2018, following Care Manager X's dismissal, failed to promptly make a formal report of his misconduct to:

   a) The Care Inspectorate;
   b) SSSC.

8) On one or more of the following occasions, failed to ensure service users were visited by carers at their scheduled times or at all:

   a) On 26 October 2018 no carer attended Service User B;

   b) On an unknown date in or around October 2018, no carer attended Service User B until 11:40pm;

c) On 25 October 2018, no carer attended Service User C;

d) On 30 October 2018, no carer had attended Service User C by 12:00pm;

e) On 16 August 2018, no carer attended Service User D for the morning visit;

f) On 29 August 2018, a carer attended Service User D:

   i) At 2:49pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm,
   ii) At 5:49pm for the dinner visit, which was scheduled between 6:00pm and 7:00pm;

g) On an unknown date, a carer attended Service User D at 3:14pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm;

h) On 31 August, carers attended Service User D at:

   i) 9:15am for the morning visit, which was scheduled for around 8:00am,
   ii) 2:24pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm,
   iii) 4:47pm for the dinner visit, which was scheduled between 6:00pm and 7:00pm;

i) On 8 October 2018, a carer attended at 2:52pm for the lunch visit, which was scheduled between 12:00pm and 1:00pm;

j) On 25 October 2018, no carer attended Service User D to assist with her bedtime routine;

k) On 26 October 2018 no carer attended Service User D for the first two scheduled visits of the day;

l) On 27 October 2018 no carer attended Service User D for the morning visit;

m) On 27 October 2018, Service User D was not attended to until 2:15pm;

n) On 27 October 2018, you did not attend the evening visit until 10:00pm;

o) On 28 October 2018, you was late attending Service User D;

p) On 29 October 2018, no carer had attended Service User D until 9:20pm;

q) On 26 October 2018, no carer attended Service Users E and F until 2:15pm;

r) On 25 October 2018, no carer attended Service User G's visit scheduled for 5:00pm until 9:35pm;

s) On 26 October 2018, no carer attended Service User G's visit scheduled for 9:30am until 10:40am.

9) Did not notify the care inspectorate of one or more of the late and/or missed visits to service users referred to in charge 8 above.

10) On or after 29 October 2018, did not follow the contingency plan when closing Standard Care.

11) Did not ensure you had unfettered access to:
   a) Standard Cares' office
   b) Care files of service users

12) Did not ensure you had adequate knowledge of the service provided by Standard Care to ensure patient safety.

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

Background

You were referred to the Nursing and Midwifery Council (NMC) on 1 December 2018 by the Edinburgh Health and Social Care Partnership in relation to Standard Care Recruitment Limited (SCRL) regarding a number of incidents which took place over a period of time between 1 August 2018 and 30 October 2018.

SCRL was a home care agency based in Edinburgh, you were the director of the agency. At the time; you were also employed as a registered nurse for NHS Lothian.

As a new service, SCRL was subject to inspections by the care inspectorate. At the first inspection in May 2018, no significant concerns in relation to the care provided to service users were identified. However, an issue came to light regarding the Care Manager that you appointed in that he had not been registered with the Scottish Social Services Council (SSSC). Further concerns about employment checks with Disclosure Scotland had also been raised. Over time, the standard of care provided by SCRL deteriorated. A number of concerns were raised by family members and friends of the service users and social work staff and are set out in the charges against you, these concerns involved elderly and vulnerable service users.

Following a number of complaints about the Care Manager, the Care Manager's dismissal and the lack of staff, you closed down the agency and asked the council to arrange for urgent alternative care to be put in place. 17 Service users were identified and the council agreed to transfer them to a mix of temporary and permanent care at home arrangements.

Admissions to charges

At the outset of the hearing Mr Mellor, on your behalf, informed the panel that you made full admissions to charges 1, 2, 3a, 3b, 3c, 4, 6, 7a, 7b, 8a, 8b, 8c, 8e, 8f (i), 8f (ii), 8g, 8h (i), 8h (ii), 8h (iii), 8i, 8j, 8k, 8l, 8m, 8n, 8o, 8p, 8q, 8r, 8s, 9, 10, 11a, 11b and 12.

Mr Mellor explained that you made partial admissions to charges 5a, 5b, 5c and 5d. You accepted that you had not ensured that staff had consistently used the equipment required to care for service users. However, you dispute the allegation that you had not ensured that staff were adequately trained in the equipment.

The panel therefore finds charges 1, 2, 3a, 3b, 3c, 4, 6, 7a, 7b, 8a, 8b, 8c, 8e, 8f (i), 8f (ii), 8g, 8h (i), 8h (ii), 8h (iii), 8i, 8j, 8k, 8l, 8m, 8n, 8o, 8p, 8q, 8r, 8s, 9, 10, 11a, 11b and 12 proved in their entirety, by way of your admissions. The panel also found charges 5a, 5b, 5c and 5d proved by way of your partial admission.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Smalley on behalf of the Nursing and Midwifery Council (NMC) under Rule 31 to allow the eight NMC witness' written statements into evidence. He drew the panel's attention to the NMC guidance and the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 Admin, which sets out the factors the panel should take into account when deciding whether or not to admit hearsay evidence.

Mr Smalley submitted that the hearsay evidence sought to be adduced includes witness statements taken during the course of the NMC's investigation. Further, he submitted that the evidence is relevant to the charges, both admitted and disputed.

Mr Smalley informed the panel that this is a joint application and that there is no disagreement between parties. Both agree that the witness evidence should be allowed and admitted as hearsay evidence.

Mr Mellor submitted that he had no objections to the evidence of the witnesses being admitted as hearsay evidence.

The panel accepted the legal assessor's advice on the issues it should take into consideration in respect of this application, which included reference to *Thorneycroft v NMC* [2014] EWHC 1565 (Admin)*.* Rule 31 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. *Thorneycroft v Nursing and Midwifery Council* provides the following factors to be taken into account:

> *(i) whether the statements were the sole or decisive evidence in support of the charges;*
> *(ii) the nature and extent of the challenge to the contents of the statements;*
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
> *(v) whether there was a good reason for the non-attendance of the witnesses;*
> *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
> *(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.*

The panel considered the submissions of Mr Smalley and Mr Mellor and accepted the advice of the legal assessor.

The panel determined that the witness statements are relevant as they relate directly to the outstanding charge and the partially admitted charges. The panel then considered the issues of fairness and had regard to the factors outlined in *Thorneycroft v NMC*.

The panel noted that all parties agree that the witness statements should be admitted as hearsay. In these circumstances, the panel determined that it would be fair and relevant to admit the witness statements as hearsay evidence.

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

Before you gave evidence under affirmation, Mr Smalley made a request that this case be held partly in private on the basis that proper exploration of your case involves reference to your personal circumstances, including details about your financial situation and your health. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Mellor, on your behalf, indicated that he supported the application.

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

Having heard that there will be reference to your personal circumstances, the panel determined to hold such parts of the hearing in private in order to protect your right to privacy and confidentiality.

Objection to question from the panel during your evidence

During the panel's questions, Mr Mellor raised an objection on the grounds that the question went beyond matters which had been raised in examination-in-chief or cross-examination. Mr Smalley submitted that the question was merely clarifying issues already raised in evidence.

The panel accepted the advice of the legal assessor.

Having considered its notes on examination-in-chief and cross-examination and the submissions of Mr Mellor and Mr Smalley, the panel concluded that the question was merely clarifying matters already raised and did not uphold Mr Mellor's objection.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the evidence in this case together with the submissions made by Mr Smalley and Mr Mellor. The panel also heard evidence from you under affirmation.

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 accepted the advice of the legal assessor.

The panel considered the remaining disputed facts, that being 8d and the partially admitted charges 5a, 5b, 5c, 5d and it made the following findings:

Charge 5a

5) Did not ensure staff were adequately trained to use and/or that they consistently used equipment required to care for service users, in that:

    a) On an unknown date in around October 2018, Service User B's catheter was left closed;

This charge is found proved.

In reaching this decision, the panel took into account all the relevant and admissible information before it, including the NMC's witness' statements and your oral evidence.

You have admitted that you did not ensure that staff consistently used the equipment (in this case the catheter) to care for service users. The panel therefore find this charge proved on the basis of this admission.

You dispute the allegation that you did not ensure that staff were adequately trained. The panel find this part of the charge not proved.

The panel noted that the witness statement from Service User B's daughter described an occasion upon which the catheter had been left closed by the carer who had attended him. This concern was reflected in the witness statement from the Social Work Team Lead employed by Edinburgh City Council. She stated "*that staff members of SCRL were not opening the clip on Service User B's catheter*". The panel noted that you were not present at the time of this incident and that you were only made aware of this incident at a later stage.

While the evidence from the Social Work Team Lead seemed to indicate that the failure to open the clip on the catheter might have happened on more than one occasion, the panel considered that the evidence from Service User B's daughter indicated that this happened on only one occasion. The panel considered that it preferred the evidence from Service User B's daughter as she was better placed to describe accurately the failure to open the clip on the catheter, having witnessed the incident herself.

The panel considered the description of the incident where Service User B's daughter indicated that this incident was more likely to have been a one-off event caused by human error rather than a failure in training.

The panel considered you to be open and honest throughout your evidence and noted that you accept that the incident took place. However, you maintained throughout your evidence that you checked for training certificates before hiring new members of staff and that you ensured staff members were trained on the use of the relevant equipment. You did this by arranging for new staff to shadow you and the Care Manager while carrying out specific tasks and using equipment.

For the reasons as set out above and due to the lack of evidence to support the disputed part of the charge, the panel decided that on the balance of probabilities, this part of the charge is found not proved.

Charge 5b

5) Did not ensure staff were adequately trained to use and/or that they consistently used equipment required to care for service users, in that:

b) On one or more occasions on unknown dates, carers pulled Service User B up by his armpits rather than using a hoist;

This charge is found proved.

The panel considered the evidence before it, including the NMC witness statements and your oral evidence.

You have admitted that you did not ensure that staff consistently used the equipment (in this case the hoist) to care for service users. The panel therefore find this part of the charge proved by admission

You dispute the allegation that you did not ensure that staff were adequately trained to use the hoist. The panel find this part of the charge not proved.

This charge arose from the witness statement of the Social Work Care Lead at Edinburgh City Council, who explains that the hoist was *"not being used properly and that staff were pulling Service User B up by his armpits"*.

You accept that this did happen but dispute that this was because carers had not been adequately trained.

The panel noted that there are a number of references made in the witness statements that indicate that you did offer training to carers in how to use the hoist. For example, the witness statement from Service User B's daughter states that *"The Council had delivered a hoist and I think she (the registrant) may have been called out to show the carers how to use it".*

The panel took into account that it had heard no evidence from any of the care assistants to say that they had not been trained properly. The panel considered your oral evidence in which you explained that you checked qualifications of new members of staff to ensure they were properly qualified. You explained what training you provided on the job, including shadowing both you and your colleague. The panel was of the view that there was no evidence before it to suggest that you had not trained carers in the use of the hoist.

For the reasons as set out above and due to the lack of evidence to support the disputed part of the charge, the panel decided that on the balance of probabilities, this part of the charge is found not proved.

Charge 5c

5) Did not ensure staff were adequately trained to use and/or that they consistently used equipment required to care for service users, in that:

    c) On around 1 September 2018, Service User D's son had to teach carers how to use the bath seat as she had not been given a bath for around 10 days;

This charge is found proved.

The panel considered the evidence before it, including the NMC witness statements and your oral evidence.

The panel considered Service User D's daughter's account of the incident. It also considered the Home Care Coordinator's evidence in relation to this charge who said that the incident was reported to her by the family. The panel noted that both individuals' accounts of the incidents corroborated.

As part of Service User D's care package, it was agreed that she could have a bath every day, or at least two or three times a week if not possible. Service User D was an

elderly vulnerable patient with urinary incontinence so it was important she was bathed regularly. However, it transpired at one point that Service User D had not had a bath for about 10 days despite Service User D's son asking a number of times for the carers to give her a bath. The witness statement from Service User D's daughter states: *"We discovered that Elizabeth did not know how to use the bath seat so my brother showed her"*. She went onto explain that it was only when Edinburgh City Council took over her mother's care that bathing happened on a regular basis.

The panel considered that this was direct evidence that the carer had not been adequately trained in the use of the bath seat, given that the family had to show her how to use it. Further it considered that the fact that Service User D was not regularly bathed during the time that SCRL was responsible for her care was further evidence that carers had not been adequately trained in its use.

Further, the panel considered your evidence in which you described the checking of training certificates and the shadowing opportunities you offered new staff. While it accepted that some training may have been offered, it determined that this could not have been adequate, given the fact that family members had to train carers to use the bath seat and that, even after this had happened, bathing did not occur on a regular basis.

For the reasons as set out above, the panel determined that it is more likely than not that the carers had not been adequately trained in the use of the bath seat. The panel therefore found this charge proved.

Charge 5d

5) Did not ensure staff were adequately trained to use and/or that they consistently used equipment required to care for service users, in that:

    d) On one or more occasion carers did not ensure Service User D was wearing her falls bracelet;

This charge is found proved.

The panel considered the evidence before it, including the NMC witness statements and your oral evidence.

Service User D wore a falls bracelet, a band she wore on her wrist so that if she fell it sent an alarm to the Council. The Council would then send someone round to Service User D to check on her. Service User D's daughter claimed that on a number of occasions Service User D would not be wearing her falls bracelet and that the SCRL carers were responsible for ensuring she was.

The panel was of the view that there was no evidence before it to suggest that Service User D was not wearing her falls bracelet due to a lack of staff training. It was of the view that Service User D may have not been wearing her bracelet for a number of reasons. The panel could not determine that this was due to inadequate staff training and therefore did not find this part of the charge proved.

Charge 8d

8) On one or more of the following occasions, failed to ensure service users were visited by carers at their scheduled times or at all:

d) On 30 October 2018, no carer had attended Service User C by 12:00pm;

This charge is found NOT proved.

The panel considered the evidence before it, including the NMC witness statements and your oral evidence.

It considered your evidence to be consistent in relation to this incident. You have admitted a number of other charges that relate to occasions when you failed to attend service users as planned. However, you were very clear that there was no duty upon

you to visit Service User C on 30th October 2018 as you had already handed over her care to Edinburgh City Council the previous evening.

You attended a meeting on 29 October 2018 having informed the Council by email at 09:32hours that day that you were triggering your contingency plan which included closing your company. It was your understanding that the Council would find alternative care arrangements for SCRL's service users as of 30 October 2018 and that you would provide care up until the end of the day on 29 October 2018.

The charge arose due to a statement within the Large Scale Investigation Outcome Report submitted by the Contract Officer at Edinburgh City Council in support of her witness statement, which indicated that the alternative care arrangements put in place by the Council only started at 5pm on 30th October 2018. However, the panel considered that this was a report completed some months after the events in question and that the specific time stamp was not supported by contemporaneous records from the time. The panel was therefore of the view that there was a lack of evidence to suggest that you were responsible for the care of Service User C at 12:00 on 30 October 2018, given your clear statement under oath that you had handed over this responsibility. While the panel considered that there was some evidence that you had continued to visit service users after 29 October 2018, it was satisfied that these visits were in support of the transition of care and that the care responsibilities had been passed to the Council at this time. The panel accepted your position and therefore found this charge not proved.

Fitness to practise

Having reached its determination on the facts, the panel went on to consider whether the facts found proved amount to misconduct, and if so, whether your fitness to practise is currently impaired. Whilst there is no statutory definition of fitness to practise, 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 to satisfy the wider public interest. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Mr Smalley made reference to a number of relevant judgments. This included *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 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.'* He also referred the panel to the following cases: *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Calheem v General Medical Council [2007] EWHC 2606.*

Mr Smalley invited the panel to take the view that the facts found proved amount to misconduct. He submitted that the panel have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision. Mr Smalley referred the panel to the relevant sections of The Code, which he submitted you had breached.

Mr Smalley further submitted that your actions have fallen far short of the standards expected of a registered nurse. He stated that the public would expect a nurse to uphold the reputation of the nursing profession at all times and that your actions amounted to a serious breach of the fundamental tenets of the nursing profession. Mr Smalley submitted that it is accepted that a number of the members of staff were not registered nurses. However, he argued that, had the care assistants had proper supervision and management, some of these incidents may not have occurred.

He submitted that separately and together, these incidents posed a significant risk of patient harm.

In light of this, Mr Smalley invited the panel to make a finding of misconduct.

Mr Mellor submitted that the question of misconduct was one for the panel to determine but asked the panel to consider whether the charges found proved could truly be described as either serious or deplorable.

Mr Mellor referred to the case of *Mr Justice Collins* in *Nandi v GMC [2004] EWHC 2317* (Admin) which states: *"the adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners."*

Mr Mellor reminded the panel that the concerns outlined in the charges occurred over a short period of time and that many were not of a serious nature. He invited the panel to consider whether the concerns identified are so serious as to amount to misconduct.

Submissions on impairment

Mr Smalley 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. He made reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927* (Admin). 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) *...'*

Mr Smalley submitted that your fitness to practise is impaired. He submitted that the first three limbs of Grant are engaged in this case. He submitted that by your own admission, you had overall responsibility for SCRL at the material time. Whilst it cannot be said that any actual harm was caused to patients, the concerns are serious and wide ranging and your conduct placed residents at unwarranted risk of harm. He referred the panel to the case of *Cohen v GMC* [2008] EWHC 581 (Admin), and the comments therein that *"it must be highly relevant in determining if a doctor's fitness to practise is impaired that first his… conduct is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."*

Mr Smalley submitted that the panel may wish to consider whether this is conduct that can be remediated, and whether this has taken place in any way. Mr Smalley submitted that the panel may consider that, as the manager of the service, the concerns identified are difficult to remedy. This may inform the panel's approach to whether there is a risk of repetition. Therefore, Mr Smalley submitted that a finding of impairment was necessary on the grounds of public protection.

Mr Smalley submitted that a finding of impairment is otherwise in the public interest. He submitted that the public confidence in the profession and the NMC as its regulator would be undermined if a finding of impairment were not made.

Mr Mellor submitted that you gave honest and straightforward evidence over a lengthy period of time. He submitted that the charges found proved date back to 2018, some four years ago. Prior to this, you had worked as a registered nurse for 34 years without incident.

[PRIVATE]

Mr Mellor provided context and described the difficult situation you found yourself in at the time. [PRIVATE] During this time period, you were trying to attend to all of the service users yourself.

Mr Mellor submitted that you had made early and comprehensive admissions to the charges. He submitted, not only had you worked 34 years as a registered nurse without concern prior to these incidents, but you have also worked as a registered nurse for the past four years.

Mr Mellor submitted that you have demonstrated an understanding of what went wrong, the complications and the difficulties caused to patients. He submitted that you have shown insight into your actions to the extent that you said you would never set up a business on your own in this way again and that you simply want to continue practising as a registered nurse.

Mr Mellor submitted that in this case, given [PRIVATE] and your subsequent employment and dedication to care for your patients and clinical work, a fully informed member of the public could and would conclude that you could practise free from restriction.

Decision and reasons on misconduct

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 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

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

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

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*
>
> ***8 Work co-operatively***
> *To achieve this, you must:*
> *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*
> *8.4 work with colleagues to evaluate the quality of your work and that of the team*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk*
>
> ***11 Be accountable for your decisions to delegate tasks and duties to other people***
> *To achieve this, you must:*
> *11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*
> *11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate*

care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges were serious and do amount to misconduct. You failed to ensure there were appropriate systems in place and/or being followed by the staff who you employed and you were ultimately responsible for the poor management and running of SCRL, placing the service users at risk of harm. Further the panel considered your failures to properly comply with the regulatory regime, through the failure to ensure your Care Manager was registered with SSSC or correctly vetted prior to commencing employment, placed service users at the risk of additional harm. [PRIVATE] However, the panel still finds that, notwithstanding these challenges, your conduct had fallen far below the standards expected of a registered nurse and therefore amounts to misconduct.

The panel determined that the charges, both individually and collectively, were serious and amounted to misconduct.

Decision and reasons on impairment

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

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold*

proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) *...'*

Whilst the panel did not have any evidence of any actual harm caused to the service users as a result of your misconduct, the panel was satisfied that the service users were put at significant risk of harm by your misconduct. Service users were left on numerous occasions with no care provided, which required family members to step in to support. Furthermore, your Care Manager continued in his role without being properly registered with the SSSC and without the checks required by Disclosure Scotland. By your own admission you did not ensure that you had adequate knowledge of the service being provided by your own agency to ensure patient safety.

The panel found that while you demonstrated remorse and had good insight into the impact of your failures on service users, your insight into the impact of your conduct on colleagues and the wider profession was still developing. [PRIVATE]. The panel accepted that you were working in challenging circumstances. However, the panel was of the view that you had not reflected fully on your own competence in managing the difficulties that arose, or on your own limitations and managerial capabilities.

The panel carefully considered the evidence before it in determining whether you have taken steps to remediate and strengthen your practice. The panel acknowledges that you stated you are up-to date with your training and that you have been practising as a nurse since these allegations arose. However, the panel had no evidence before it that you had completed recent relevant training related to, for example, leadership and management, safer recruitment processes or relevant regulatory frameworks. You provided a positive testimonial from your line manager in your current nursing role but this did not attest to your managerial skills.

The panel is therefore of the view that there is a risk of repetition should you be in a similar managerial situation again. It considered that you have not fully reflected on the role you played in respect of the serious failings at the agency, despite the significant passage of time. Further the panel considered that you have not reflected fully on your own limits and capabilities when faced with the challenges the agency presented. You have described the significant impact these proceedings have had on you but you do not appear to have fully considered how you would do things differently if faced with a similar challenging situation. Rather, you have responded by stating you will never set up an agency again. The panel recognised that you have not had a managerial role since 2018 and have stated you have no intention of returning to such a role. However, the panel is of the view that this further emphasises that your practice remains impaired. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and

protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel considered that a well-informed member of the public, having been informed of all the circumstances of your case, would expect a regulator to take action to uphold proper professional standards, given the significant failures identified. The provision of regular and reliable care to elderly and vulnerable service users is fundamental to the effective provision of care services and your failure to run the agency competently in this respect means that a finding on public interest grounds is also required.

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

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 36 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been presented 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 Smalley invited the panel to consider the SG and note, in particular, that the purpose of any sanction is to protect the public interest so as to protect patients and others,

maintain public confidence in the profession and its regulator, and to declare and uphold proper standards of conduct and behaviour.

Mr Smalley directed the panel to the SG and in particular SAN-3c. Mr Smalley submitted that an aggravating feature in your case was the risk of harm, on multiple occasions, to multiple service users. However, Mr Smalley submitted that there is evidence of your good nursing practice at your current role at NHS Lothian, albeit not in the area of management. He submitted that there is no evidence of any harmful, deep-seated or attitudinal problems in relation to your practice. Further, there is no evidence of general incompetence in terms of working as a registered nurse. Mr Smalley asked the panel to consider these factors as mitigating features in your case.

Mr Smalley submitted that this is a case in which conditions could be drafted to address the specific concerns that arise from the charges found proved. He submitted that the imposition of a conditions of practice order would meet the panel's obligations on proportionality and do no more than what is necessary to meet the public interest concerns identified. He therefore invited the panel to impose a conditions of practice order.

Mr Mellor indicated that he was in agreement with Mr Smalley's submissions. He told the panel that you worked as a registered nurse for 34 years prior to the incident and have worked for a further four years since the incident without any concerns about your practice. You are, he submitted, someone who has a "*passion*" for nursing. He submitted that what happened in 2018 had been a disaster for someone who was *"a good nurse but not a good business woman".*

Mr Mellor reminded the panel that you admitted almost all of the charges when the concerns first came to light, some four years ago. Mr Mellor submitted that whatever sanction the panel chooses to impose should be the least restrictive as possible, given your proven record of being a good, capable and caring nurse.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Your conduct put vulnerable service users at risk of harm;
- A number of service users were impacted by your actions; and
- Your poor management skills were demonstrated on multiple occasions.

The panel also took into account the following mitigating features:

- You made admissions to the majority of the charges, when the allegations first came to light;
- There is no evidence of general incompetence as a nurse;
- Your insight is developing;
- You have demonstrated genuine remorse for your failings;
- You have practised for 38 years without there being a complaint to your regulator, other than on this occasion; and
- [PRIVATE]

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 failings that need to be addressed before you could practice without restriction. 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 your 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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified, given the potential harm to a number elderly and vulnerable patients on a number of occasions. 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the guidance about when the conditions of practice order may be appropriate and determined that the following points were applicable in your case:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practicable conditions which would address the failings highlighted in this case. The panel considered that there was no indication that you would be unwilling to comply with a conditions of practice order.

The panel noted that the concerns were centred around your poor managerial skills. It also had regard to the fact that these incidents happened a long time ago and that, other than these incidents, you have had an otherwise unblemished career of 38 years

as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel determined that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case, because a conditions of practice order is the least restrictive order that would sufficiently address the concerns identified in your practice, protect the public and meet the public interest.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must not set up an agency or business that provides any nursing or care to clients.

2. You must not take on any new managerial nursing or care position that requires you to directly line manage other members of staff unless you are supervised by a line manager. In this situation, your supervision must consist of fortnightly meetings to discuss

your managerial responsibilities. These should include (but are not restricted to):

- your monitoring of your line reports' performance and capabilities
- communication with relevant stakeholders to maintain patient safety
- the effectiveness of any care plans that are completed by your team
- upholding regulatory responsibilities as appropriate.

3. If you are employed in any managerial role requiring you to directly line manage other members of staff, you must keep a reflective practice profile. The profile will:
    - Detail each line report for whom you are responsible
    - Set out the actions you have taken to ensure that your line report practises safely and effectively
    - Be signed by your own line manager each time
    - Contain feedback from those who are your direct line reports on the effectiveness of the support you have given them in fulfilling their roles.

4. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

5. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

7. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 36 months. It determined that a period of 36 months would allow you to continue to practise in your current role as a nurse while at the same time giving you opportunity to develop your insight. Further, it will allow you to undertake any relevant training you may wish to complete should you decide you wish to take on any new managerial position in the future. The panel also considered that an order of 36

months meant that you would not be required to return to the NMC for frequent reviews if you decided that you did not wish to take up any managerial position. The panel was satisfied that in the event that you have fulfilled the requirements of the conditions of practice order earlier, then you can request an early review.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at the next review hearing.
- A reflective piece that demonstrates your understanding of the impact of your misconduct on others, particularly service users.
- Evidence of professional development, including documentary evidence of training records.
- References and testimonials from any paid or unpaid work.
- Any evidence you may have collated that attests to your mentoring of staff or support for colleagues' professional development.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Smalley. He submitted that an interim order was required on public protection and public interest grounds for the same reasons given for the substantive conditions of practice order. Mr Smalley invited the panel to make an interim conditions of practice order for a period of 18 months to cover any appeal period until the substantive conditions of practice order takes effect. He submitted that the interim conditions of practice order would not cause you any hardship.

The panel also took into account Mr Mellor's submissions who did not oppose the application for an interim order.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be inconsistent with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to ensure that you cannot practise unrestricted before the substantive conditions of practice order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.