Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday 8 – Wednesday 9 August 2023

Virtual Meeting

Name of Registrant:	**Paul Bola Oluleye**
NMC PIN	10I4470E
Part(s) of the register:	Nursing – Sub Part 1 Adult Nursing – Level 1 (December 2012)
Relevant Location:	Stoke-on-Trent
Type of case:	Misconduct
Panel members:	Simon Banton (Chair, Lay member) Shorai Dzirambe (Registrant member) Jan Bilton (Lay member)
Legal Assessor:	Robin Ince
Hearings Coordinator:	Elena Nicolaou
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15 and 16
Facts not proved:	Charge 7
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mr Oluleye's registered email address by secure email on 19 June 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting would be held virtually.

In the light of all of the information available, the panel was satisfied that Mr Oluleye has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Personal matters

The panel acknowledged that although this meeting would held privately in any event, it would determine what parts, if any, need to be redacted should any private matters arise in the determination.

Decision and reasons on application to amend the charge

The panel, of its own volition, decided to amend charges 15 and 16.

The proposed amendment was to change the wording of charges 15 and 16 to instead say:

15. *On 12 June 2021 failed to administer Ramipril ~~25mg~~ **2.5mg** to Resident E.*

16. *On 12 June 2021 incorrectly entered on Resident E's MAR chart that Ramipril ~~25mg~~ **2.5mg** had been administered to Resident E when it had not.*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules. It noted that the prescribed dose of Ramipril on Resident E's Medication Administration Record (MAR) chart was 2.5mg and not 25mg as stated in charges 15 and 16. Accordingly, the amendment was required in order to ensure accuracy.

The panel was of the view that such an amendment was in the interests of justice. The panel was satisfied that there would be no prejudice to Mr Oluleye and no injustice would be caused to either party by the proposed amendment being allowed. The mischief of the charges was the failure to administer or accurately record the administration of Ramipril and not the amount of the medication. It was therefore appropriate to allow the amendment to ensure clarity and accuracy based on the evidence before it.

Details of charge (as amended)

That you a registered nurse;

1. On 26 January 2021 failed to administer Gabapentin 600mg to Resident A.

2. On 26 January 2021 incorrectly entered on Resident A's MAR chart that you had administered Gabapentin 600mg to Patient A when only Gabapentin 300mg was administered.

3. On 7 February 2021 failed to administer Furosemide 40mg to Resident B.

4. On 7 February 2021 incorrectly entered on Resident B's MAR chart that you had administered Furosemide 40mg to Patient B when it was not administered.

5. On 5 February 2021 failed to administer Trimethoprim 100mg to Resident C.

6. On 5 February 2021 incorrectly entered on Resident C's MAR chart that you had administered Trimethoprim 100mg to Resident C when it was not administered.

7. On 27 January 2021 failed to administer Venlafaxine 150mg to Resident C.

8. On 8 February 2021 failed to administer Trimethoprim 100mg to Resident C.

9. On 8 February 2021 incorrectly entered on Resident C's MAR chart that Trimethoprim 100mg was administered to Resident C when it had not.

10. On 10 May 2021 incorrectly administered Mirtazapine 30mg to Resident D in the morning.

11. On 7 June 2021 failed to administer Lansoprazole 15mg to Resident D.

12. On 7 June 2021 incorrectly initialled Resident D's MAR Chart that Lansoprazole 15mg was administered to Resident D when it had not.

13. On 12 June 2021 failed to administer two capsules of Pregabalin 75mg to Resident C.

14. On 12 June 2021 incorrectly entered on Resident C's MAR chart that Pregabalin 75mg had been administered to Resident C when it had not.

15. On 12 June 2021 failed to administer Ramipril 2.5mg to Resident E.

16. On 12 June 2021 incorrectly entered on Resident E's MAR chart that Ramipril 2.5mg had been administered to Resident E when it had not.

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

Background

The charges arose whilst Mr Oluleye was employed as a registered nurse at Scotia Heights Care Home (the Home). At the time of the alleged incidents, Mr Oluleye was working as a staff nurse at the Home, mainly on night shifts. He had worked at the Home in this role since October 2019. The Home cares for residents with mental health and nursing needs.

The concerns in this case arise out of a series of instances whereby Mr Oluleye allegedly made a number of errors in medication management and record keeping between January and June 2021. The errors became known as the Home had a medication tracking system in use to identify errors and discrepancies in stock counts.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witness on behalf of the NMC:

- Witness 1: Deputy Home Manager; the Home

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

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

Charges 1 and 2

1. *On 26 January 2021 failed to administer Gabapentin 600mg to Resident A.*

2. *On 26 January 2021 incorrectly entered on Resident A's MAR chart that you had administered Gabapentin 600mg to Patient A when only Gabapentin 300mg was administered.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it. The panel took charges 1 and 2 together when making its decision as they are linked to the same incident.

The panel established that Resident A and Patient A were the same person.

It considered Witness 1's statement, which stated:

> *'On 26 January 2021 the Nurse signed that they had administered Resident A 600mg of Gabapentin, when in fact they had only administered 300mg of Gabapentin instead of the 600mg of Gabapentin that they had signed for'.*

The panel also had sight of Resident A's MAR chart, which clearly indicates that Mr Oluleye signed for the 300mg dose of Gabapentin and his initials are shown. The panel noted that there were 26 tablets recorded within the medication stock and this was recorded on the chart by the nurse that completed the stock check, when there should have been 25 tablets.

The panel also took account of the contemporaneous Adverse Event form which documents the above incident.

Therefore in light of the above, the panel found charges 1 and 2 proved.

Charges 3 and 4

3. *On 7 February 2021 failed to administer Furosemide 40mg to Resident B.*

4. *On 7 February 2021 incorrectly entered on Resident B's MAR chart that you had administered Furosemide 40mg to Patient B when it was not administered.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it. The panel took charges 3 and 4 together when making its decision as they are linked to the same incident.

The panel established that Resident B and Patient B were the same person.

It considered Witness 1's statement, which stated:

> *'On 8 February 2021, an AE1 form was completed by a Staff Nurse at the Home who was conducting a stock check. The Staff Nurse…. Found that Resident B had missed their dose of Furosemide and stock counted eight tablets of Furosemide instead of the 7 that the Nurse had signed for.'*

The panel also took account of Resident B's MAR chart, which clearly indicates that a dosage of one Furosemide was missed on 7 February 2021, although it was signed for by Mr Oluleye. As per Witness 1's statement, the nurse that undertook a stock check the following day found that the count was incorrect, and had documented the correct amount on the chart.

A contemporaneous Adverse Event form was also completed which documents the above incident.

Therefore in light of the above, the panel found charges 3 and 4 proved.

Charges 5 and 6

5. *On 5 February 2021 failed to administer Trimethoprim 100mg to Resident C.*

6. *On 5 February 2021 incorrectly entered on Resident C's MAR chart that you had administered Trimethoprim 100mg to Resident C when it was not administered.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it. The panel took charges 5 and 6 together when making its decision as they are linked to the same incident.

The panel considered Resident C's MAR chart, which clearly indicates that the dosage of one Trimethoprim was missed on 5 February. It noted that there were 10 tablets, and Mr Oluleye recorded the stock count as nine tablets. The nurse that undertook another stock check the following day found that there were still nine tablets present after they had administered the medication, which indicates that Mr Oluleye had administered the prescribed dose.

Therefore in light of the above, the panel found charges 5 and 6 proved.

Charge 7

7. *On 27 January 2021 failed to administer Venlafaxine 150mg to Resident C.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel considered that the running total for Venlafaxine was correct which would indicate that it was administered to Resident C correctly. It noted that the prescription

stated that Resident C required two tablets of Venlafaxine which was administered and documented.

Therefore in light of the above, the panel found charge 7 not proved.

Charges 8 and 9

8. *On 8 February 2021 failed to administer Trimethoprim 100mg to Resident C.*

9. *On 8 February 2021 incorrectly entered on Resident C's MAR chart that Trimethoprim 100mg was administered to Resident C when it had not.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it. The panel took charges 8 and 9 together when making its decision as they are linked to the same incident.

The panel took account of the MAR chart for Resident C, which clearly indicates that eight Trimethoprim tablets were present the previous day. When Mr Oluleye came on duty on 8 February, he had signed that seven tablets were left. When a nurse undertook another stock check the following day, they had found that seven tablets were still present after they had administered the medication, which would indicate that the dosage was missed on 8 February.

The panel noted that Mr Oluleye had signed for Trimethoprim when it was clearly not administered to Resident C.

Therefore in light of the above, the panel found charges 8 and 9 proved.

Charge 10

10. *On 10 May 2021 incorrectly administered Mirtazapine 30mg to Resident D in the morning.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel took account of the MAR chart for Resident D, which clearly indicates that Mr Oluleye signed for one Mirtazapine which was administered at 06:30 hrs on the morning of 10 May. The panel considered that the prescription states Mirtazapine should be administered at night time.

The panel also had sight of the contemporaneous Adverse Event form which Mr Oluleye signed, admitting to the above incident, and he had also left a note for the next day staff nurse on duty to take this into account.

Therefore in light of the above, the panel found charge 10 proved.

Charges 11 and 12

11. *On 7 June 2021 failed to administer Lansoprazole 15mg to Resident D.*

12. *On 7 June 2021 incorrectly initialled Resident D's MAR Chart that Lansoprazole 15mg was administered to Resident D when it had not.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it. The panel took charges 11 and 12 together when making its decision as they are linked to the same incident.

The panel took account of Resident D's MAR chart, which clearly states that one 15mg Lansoprazole tablet should be taken in the morning. Mr Oluleye had signed that he administered this dosage, but he did not record the running total.

The staff nurse that took over the following day recorded that 27 tablets were present after they had administered the medication, which would indicate that Mr Oluleye did not administer the Lansoprazole for Resident D as prescribed.

The panel also considered the contemporaneous Adverse Event form which documents the above incident.

Therefore in light of the above, the panel found charges 11 and 12 proved.

Charge 13 and 14

13. *On 12 June 2021 failed to administer two capsules of Pregabalin 75mg to Resident C.*

14. *On 12 June 2021 incorrectly entered on Resident C's MAR chart that Pregabalin 75mg had been administered to Resident C when it had not.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it. The panel took charges 13 and 14 together when making its decision as they are linked to the same incident.

The panel took account of Resident C's MAR chart, which clearly states that two 75mg Pregabalin tablets were to be taken twice a day. The panel noted that on 12 June 2021 Mr Oluleye administered two tablets in the morning but none at bedtime. It also noted that 90 instead of 88 tablets remained in stock.

The panel also considered the contemporaneous Adverse Event form which documents the above incident.

Therefore in light of the above, the panel found charges 13 and 14 proved.

Charge 15 and 16

15. *On 12 June 2021 failed to administer Ramipril 2.5mg to Resident E.*

16. *On 12 June 2021 incorrectly entered on Resident E's MAR chart that Ramipril 2.5mg had been administered to Resident E when it had not.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it. The panel took charges 15 and 16 together when making its decision as they are linked to the same incident.

The panel took account of Resident E's MAR chart which clearly states that on the previous shift the running total of Ramipril was 23 tablets. When Mr Oluleye came on duty on 12 June, he documented that 22 tablets were left. The staff nurse that took over the following day reported that 22 tablets were still remaining after they had administered the medication, which would indicate that the dosage was missed on 12 June for Resident E.

The panel also considered the contemporaneous Adverse Event form which documents the above incident.

Therefore in light of the above, the panel found charges 15 and 16 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 Oluleye'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 Oluleye's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'

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

The NMC identified the specific, relevant standards where Mr Oluleye's actions amounted to misconduct. The written submissions are as follows:

'***Misconduct***

The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:

> *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances.'*

As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively

> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired.'*
>
> *And*
>
> *'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 practitioner.'*

Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct.

We consider the following provision(s) of the Code have been breached in this case:

> ***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*
10.3 *complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

We consider the misconduct serious because it involves a considerable number of serious medication errors, signing for medication that he did not administer, over a prolonged period of time, even after local intervention. The repeated errors in spite of local support gave rise to a real risk of harm to the public on numerous occasions. This must be deemed as serious such that it would be regarded as deplorable by a fellow nurse.'

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel was referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mr Oluleye's fitness to practise impaired. The written submissions are as follows:

*'**Impairment***

The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. The question that will help decide whether a professional's fitness to practise is impaired is:

"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.

Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.

When determining whether the Registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:

1) *has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
2) *has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
3) *has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*
4) *has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.*

It is the submission of the NMC that 1, 2, and 3 can be answered in the affirmative in this case.

Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

It is submitted that Mr Oluleye has displayed extremely limited insight. Despite engaging at a local level, admitting all the errors, he attributed them to 'human error.' He has not provided any formal responses to either the regulatory concerns or the charges, and has not provided any reflective statements that could evince insight into the seriousness of his errors. Moreover, Mr Oluleye has failed to provide any evidence of remediation, either through training or work as a nurse since August 2021. Accordingly, it is submitted that there remains a serious risk to the public should Mr Oluleye return to nursing.

In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

> *"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."*

Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.

In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which has not been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.

It is submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Medication administration and record keeping form fundamental parts of nursing practice. The public rightly expect nurses to perform these duties safely and professionally, and as such, the absence of a finding of impairment in this case risks undermining public confidence in the profession.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v GMC, Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mr Oluleye'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:

'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:

10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

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

To achieve this, you must:

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

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'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered all of the documentary evidence before it. It considered that, as a whole, the charges found proved amount to misconduct. Mr Oluleye was the nurse responsible for the administration of medications for residents under his care whilst on duty, and these incidents occurred over a period of six months. The panel considered that the incidents are similar in nature and indicate a pattern in Mr Oluleye's practise.

The panel determined that Mr Oluleye did not follow the prescriber's instructions which were clearly documented on each of the resident's MAR charts. Furthermore, that the record keeping in relation to these medication errors was also incorrect and was misleading. It noted that there were times Mr Oluleye was signing that he had administered the medication when this was not the case, and this resulted in residents missing their prescribed dosages.

The panel reminded itself that administration of medication is a fundamental aspect of nursing practice. It considered that these medication errors were avoidable, and the MAR charts were clear in their instructions. It considered that whilst there is no evidence before it that actual harm was caused to any residents, there was a potential risk of harm. It considered the potential consequences of missed medication, for example if a resident does not receive the required pain relief, they could be left in significant pain and discomfort.

The panel considered that, when taking the charges together cumulatively, they would amount to serious misconduct and would be seen as deplorable by other healthcare professionals.

The panel therefore found that Mr Oluleye'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 Oluleye'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. 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/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

d) …

The panel finds that residents were put at a risk of harm as a result of Mr Oluleye's misconduct. It considered that there is a high risk that Mr Oluleye would repeat his actions in the future as there is no evidence before the panel to demonstrate that he has addressed the concerns or strengthened his practice.

The panel considered that Mr Oluleye's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered that there is no evidence before it that Mr Oluleye has demonstrated insight, reflection or remorse for his actions. There is no evidence of further training having been undertaken by him, nor any testimonials to speak to his current or any recent nursing practice. Therefore, the risk of harm and the risk of repetition remains high.

The panel noted that there is reference made to a reflection provided during the local investigation, but it has not had sight of this.

The panel acknowledged that Mr Oluleye had previously stated in a local interview that took place in July 2021 that he was considering no longer practising as a nurse. The panel has no further information before it regarding his position on returning to nursing practice.

In light of the above, the panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required as a well-informed member of the public would be concerned to learn of Mr Oluleye's actions that repeatedly occurred over a period of six months.

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

Having regard to all of the above, the panel was satisfied that Mr Oluleye's 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 12 months. The effect of this order is that Mr Oluleye's name on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 19 June 2023, the NMC had advised Mr Oluleye that it would seek the imposition of a six-to-nine-month conditions of practice order (with a review) if it found his fitness to practise currently impaired. The written submissions are as follows:

*'**Sanction***

We consider the following sanction is proportionate:

Conditions of practice order for a period of 6-9 months with a review

With regard to our sanctions guidance the following aspects have led us to this conclusion:

27.1. Taking no further action and Caution order: These sanctions would not address on the ongoing public protection concerns in this case. There remains a risk to the health, safety, and well-being of the public because Mr Oluleye has not demonstrated sufficient insight as to the risks involved in not providing medication to vulnerable patients. In addition, he has not sought to remediate the concerns and as such there remains an ongoing risk that the concerns could be repeated.

27.2. Conditions of practice order: It is submitted that this would be the most appropriate sanction to impose in this case. It would be proportionate taking into consideration that the conduct relates to medication and documentation errors occurring on multiple occasions. Under conditions of practice, should Mr Oluleye return to nursing, the risk to the public can be managed through measurable and workable conditions, such as supervision and development plans.

27.3. Suspension and striking off orders: These orders would be excessive in the circumstances of this case. The misconduct in this case has been admitted, relating to discreet, identifiable concerns for which suitable conditions of

practice can be imposed. Accordingly, removal from the register, be it temporary or permanent, is unnecessary and disproportionate in the principal aims of protecting the public and maintaining public confidence in the profession.'

Decision and reasons on sanction

Having found Mr Oluleye'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 Sanctions Guidance (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:

- No evidence of insight, reflection or remorse by Mr Oluleye;
- A pattern of misconduct over a period of time;
- Conduct which placed residents at risk of harm.

The panel also took into account the following mitigating features:

- Some evidence of personal health issues, but no detail of these or supporting documentation was before the panel.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Oluleye'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 Oluleye's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *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 practical conditions which would address the failings highlighted in this case. The panel considered that the concerns in this case are remediable and imposing a conditions of practice order would allow Mr Oluleye a further opportunity to return to nursing and address those concerns.

The panel considered that there is no evidence before it that any other aspects of Mr Oluleye's practice have been called into question, apart from the medication errors and record keeping in relation to those errors.

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

The panel was of the view that to impose a suspension order or a striking-off order at this stage would be wholly disproportionate and would not be a reasonable response in the

circumstances of Mr Oluleye's case. The concerns in this case can be addressed by appropriate conditions of practice in place.

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 place yourself under the supervision of another registered nurse when administering medication until you complete your employer's safe administration of medication training and have been assessed as competent to independently administer medicines.

2. You must within seven days of the completion of the training and competency assessment, referred to in condition one, send evidence to your NMC case officer that you have completed your employer's safe administration of medication training and have been assessed as competent to independently administer medicines.

3. You must meet with your line manager at least every six weeks and discuss your progress in the administration of medication and record keeping.

4. You must provide a report from your line manager that discusses your progress in the administration of medication and record keeping to any future review panel.

5. You must keep the NMC 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.

6. You must keep the NMC 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.

7. 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.

8. 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.

9. 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 12 months, with a review.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mr Oluleye has 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:

- A report from your line manager that discusses your progress in administration of medication and record keeping.
- Evidence of training undertaken.
- Testimonials whether from paid or unpaid work.
- A written reflective piece that addresses the concerns found proved.

This will be confirmed to Mr Oluleye 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 Mr Oluleye's own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the written representations made by the NMC:

> *'**Interim Order Consideration***
>
> *If a finding is made that the registrant's fitness to practise is impaired on a public protection basis, and a restrictive sanction imposed, we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.'*

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible 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 allow for the possibility of an appeal to be made and 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 Mr Oluleye is sent the decision of this hearing in writing.

That concludes this determination.