Nursing and Midwifery Council
Fitness to Practise Committee
Substantive Hearing
12 – 19 August 2019
5 – 10 February 2020
2 – 4 March 2020

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

Name of registrant:	Oluyemi Idowu Ipadeola
NMC PIN:	05B0081O
Part(s) of the register:	Registered Nurse – Sub part 1 – Adult Nursing (3 February 2005)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Joy Julien (Chair, Lay member) Deborah Hall (Registrant member) Helen Hoult (Registrant member)
Legal Assessor:	Ian Ashford-Thom
Panel Secretary:	Amira Ahmed (12 – 19 August 2019) Akunna Iwuagwu (5 – 10 February 2020) Akunna Iwuagwu (2 – 4 March 2020)
Mrs Ipadeola:	Not present 12 August 2019 but represented by Dr Olu Taiwo, TBA Legal Present from 14-19 August 2019 Not present and not represented 2 – 4 March 2020
Nursing and Midwifery Council:	Represented by Amy Woolfson, Case Presenter
Facts proved:	1 (a) – (d), 2, 3, 4 and 5 (in relation to Resident G only)
Facts not proved:	None
Fitness to practise:	Impaired

Sanction: Striking-off order

Interim Order: Interim suspension order (18 months)

Details of charge:

That you, a registered nurse:

1. While working at Newlands Care Home between 4 February and 8 July 2016:

   (a) On an unknown date, forcibly administered medication to Resident E using a spoon with no food or liquid on it.

   (b) On an unknown date, forcibly administered food to Resident D using a spoon.

   (c) During the incident in Charge 1(b), above, said to Colleague A “that was how it had to be done as the resident had dementia” or words to the effect.

   (d) On or around 16 March 2016, conducted a rectal examination of Resident F without giving prior warning and/or obtaining consent before doing so.

   [found proved in its entirety]

2. On a date prior to 19 May 2016, submitted an application form for employment as a staff nurse at Moston Grange Care Home without disclosing your previous employment at Newlands Care Home. ***[proved by admission]***

3. On or around 6 September 2016, submitted an application form for employment as a registered nurse at Cale Green Nursing Home, without disclosing your previous employment at Newlands Care Home. ***[proved by admission]***

4. Your conduct in Charge 2 and/or Charge 3, above, was dishonest in that you knowingly attempted to conceal that you were the subject of a safeguarding investigation relating to your employment at Newlands Care Home. ***[found proved]***

5. On one or more occasions between 28 September 2016 and 18 November 2016 while working at Cale Green Nursing Home you provided a drink to Resident G and/or Resident H while they were laying down flat. ***[found proved]***

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

Application to Adjourn under Rule 32 (Day 2)

After the reading of the charges Dr Taiwo, on Mrs Ipadeola's behalf, made an application pursuant to Rule 32 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules"), to adjourn the proceedings on day 2 of the hearing. Dr Taiwo told the panel that he had not seen the charges in their present form before they were read out today. He told the panel that he needed time to get proper instructions from Mrs Ipadeola on the charges that have been read out. He explained that he understands that there may be witnesses present today who are due to give evidence and apologised for any inconvenience caused to them by an adjournment. He asked the panel to consider an adjournment longer than one day, yet did not request a specific period of time.

Ms Woolfsen, on behalf of the NMC, opposed this application. She submitted that the charges had been sent to Dr Taiwo and by recorded delivery to Mrs Ipadeola in their present form on 12 July 2019 at the latest. She further submitted that Dr Taiwo has had a sufficient amount of time to get instructions from Mrs Ipadeola. Ms Woolfsen explained that the courts have indicated the need to avoid a culture of adjournments. She reminded the panel of the public interest in the expeditious disposal of cases.

The panel accepted the advice of the legal assessor.

The panel had regard to the public interest in the expeditious disposal of cases and the inconvenience that may be caused to witnesses that are scheduled to give evidence, but considered that fairness to Mrs Ipadeola required an adjournment, whilst avoiding if possible inconvenience to witnesses and undue delay in concluding this hearing. The panel therefore granted Dr Taiwo's application to adjourn these proceedings on day 2 of the hearing. The panel decided that a short adjournment of one day would be sufficient to enable Dr Taiwo to take instructions from Mrs Ipadeola.

Facts

At the outset of the hearing, the panel heard from your representative Dr Taiwo, who informed the panel that you made full admissions to charges 2 and 3. The panel therefore finds charges 2 and 3 proved in their entirety, by way of your admissions.

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

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

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

- Ms 1: Owner and CQC registered provider for Cale Green Nursing Home.
- Ms 2: HCA and Team Leader at Cale Green Nursing Home.
- Mr 3: Health Care Assistant employed by Newland's Care Home.

The panel also heard evidence from you on oath.

Background:

You were first registered as a nurse in the UK in February 2005, and have been qualified as a nurse in Nigeria and Jamaica for approximately 20 years previously. The charges arose whilst you were employed as a registered nurse at Newlands Care Home (the Home), Moston Grange Care Home (Moston Grange) and Cale Green Nursing Home (Cale Green) in 2016. The three establishments are Nursing Homes that provide care for vulnerable adults.

The NMC received a referral from Cale Green on 12 October 2016 in relation to your nursing practice.

The charges you face broadly relate to your patient care, safeguarding of vulnerable adults, failing to disclose your previous employment to two prospective employers and dishonesty.

Incidents at the Home

You were employed as a registered nurse at the Home from 4 February 2016 until 8 July 2016. The Home is a residential home that has 21 residents on the nursing floor who suffer from dementia.

It is alleged that on an unknown date you were witnessed forcibly administering medication to Resident E using a spoon with no food or liquid on it. It is also alleged that you forcibly administered food to Resident D.

Mr 3 provided a witness statement and gave oral evidence in relation to the above alleged incidents. In his witness statement Mr 3 stated he was feeding Resident D, a resident who was unresponsive so took longer to feed. Mr 3 alleged that you came up to him, snatched a spoon and forced the food into Resident D's closed mouth twice. Mr 3 alleged that after this incident, you stated "*that's how you have got to do it… she's got dementia"* or words to that effect. This was supported by Mr 3's oral evidence.

On another occasion it is also alleged that following a colleague alerting you to the fact that blood was seen in Resident F's stool, without any notice and without permission from the resident, you conducted a rectal examination of Resident F. Mr 3 alleged that he reported all the incidents he witnessed to the Home's management.

You were made the subject of a safeguarding investigation in relation to the incident relating to Resident F. You were suspended from the Home on 23 March 2016. The safeguarding issues were also referred to the police and criminal proceedings were issued against you. You were found not guilty following a trial in the Crown Court.

You deny the allegations and state that they were fabricated by Mr 3, who you alleged did not like you.

Charges 2 and 3 relate to you submitting application forms to Moston Grange and Cale Green without disclosing your previous employment at the Home. You admitted these charges.

It is further alleged that you failed to inform Moston Grange and Cale Green about your employment with the Home as an attempt to conceal the fact that you were subject to safeguarding investigations and your actions were therefore dishonest. Your alleged dishonest act forms the basis of Charge 4.

You denied that your actions were dishonest. You stated that your actions of non-disclosure and lack of transparency in relation to your previous employment at the Home were honest omissions.

Moston Grange terminated your employment on 21 October 2016 during a probation meeting as they were concerned about both your lack of disclosure and transparency with regard to your employment and the ongoing investigation in relation to the safeguarding allegations raised by the Home.

Incidents at Cale Green

Safeguarding allegations were also raised at Cale Green in relation to your patient care. It is alleged that between 28 September 2016 and 18 November 2016 you provided a drink to Resident G and/or Resident H while they were laying down flat.

Ms 2 gives direct evidence to this incident. She states that she and another HCA witnessed you try to give two different residents fluids whilst they were laying down flat.

These incidents were reported to management at Cale Green. Ms 1 gives evidence in relation to reports being made to her that you had given residents fluids whilst laying down flat.

A local investigation was conducted and there was no evidence of this conduct being detailed on the residents' notes.

You deny the allegations. You stated that the staff at Cale Green had issues with you and fabricated these allegations against you.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The legal assessor referred the panel to the case *of Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 where it was stated:

"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be decided by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest".

The legal assessor reminded the panel of your good character and its potential relevance to your credibility and the likelihood of you being guilty of these charges.

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from, including you. The panel was of the opinion that all the witnesses called by the NMC have tried to assist the hearing to the best of their knowledge and belief. However the panel had some reservations about aspects of your evidence.

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

The panel found Ms 1 to be an open, credible and reliable witness. It considered Ms 1 to be very positive and supportive of you. The panel noted that Ms 1 was able to provide additional contextual information requested of her when giving her oral evidence. It found Ms 1 to be an honest, fair and balanced witness. Overall, the panel found Ms 1's evidence to be consistent, credible and of a high standard.

The panel was mindful that on agreement by both parties, Ms 2 gave evidence by way of video link and took this into account when assessing the quality of the evidence she gave.

The panel found Ms 2 to be inconsistent and unsure of her recollection of events in relation to documenting and reporting the incidents she allegedly witnessed. The panel noted that Ms 2 was nervous about giving evidence and was at times defensive.

Even though there were some inconsistencies, the panel considered Ms 2 to have given a coherent and detailed account of events to what she witnessed. The panel found Ms 2's oral evidence on what she witnessed to be consistent with her account detailed in the interview notes between her and Cale Green Management on 1 December 2016 and also in most respects with her police witness statement dated 18 January 2017. Overall the panel found Ms 2 to be credible and reliable in describing what she witnessed.

The panel found Mr 3 to be an open and reliable witness whose oral evidence was broadly consistent with his police and NMC witness statements. The panel found Mr 3 to be very clear and detailed in relation to the sequence of the incidents he witnessed whilst giving his oral evidence. He did not attempt to mislead the panel or embellish the evidence he gave. The panel found that Mr 3 readily admitted his failings whilst giving oral evidence in relation to not following up his complaint with management at the Home by accepting that he was *"naïve"* to expect management to escalate his concerns without chasing progress. The panel noted that Mr 3 gave credible, focused and prompt responses to questions asked. In all, the panel found Mr 3 gave clear, calm and consistent evidence.

In relation to your evidence, the panel acknowledged that you were entitled to be given credit as a witness who was of good character, with testimonials to that effect and bore that in mind when assessing your credibility and explanations provided.

However, the panel found you to be a less credible witness who was inconsistent in some of the evidence you gave. It felt that at times your answers were lengthy without being direct, despite being asked direct questions. An example being, when a panel member asked you to explain why you have two different explanations in relation to not disclosing your previous employment at the Home to Cale Green and Moston Grange and you stated:

"I am apologising that I did not put it there because at the time, during any time I remember Newlands, it is breaking my heart, because the way I worked, I have never worked before. The floor was full with…we have about three… They write me with all these false allegations". [sic]

The panel found that often you did not give specific answers to questions asked but gave unclear, evasive and at times, hypothetical answers. The panel found your answers lacked detail in relation to most of the charges. It noted that your answers deflected onto the Home and your experiences whilst working there rather than address the charges. The panel however found that you were consistent in your simple denial of the charges.

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

Charge 1a:

1) While working at Newlands Care Home between 4 February and 8 July 2016:

a) On an unknown date, forcibly administered medication to Resident E using a spoon with no food or liquid on it.

This charge is found proved.

The panel took into account all the NMC's witnesses' evidence as well as your evidence.

In reaching this decision, the panel took account of Mr 3's witness statement to the police dated 11 July 2016, his statement to the NMC dated 19 January 2019 and his oral evidence.

The panel had regard to Mr 3's written statement where he stated '*As we walked past another room that day, I saw the registrant for the first time. She was giving out medication. She had a soup spoon and she had 3 or 4 tablets on it. She was ramming the spoon hard into the resident's mouth… I noticed that there was no food or liquid on this resident's spoon - just tablets - which wasn't normal'.*

The panel considered Mr 3 to have been sufficiently concerned by what he witnessed to have immediately raised the issues with another member of staff who informed him that she had escalated the concerns to management. The panel noted that there was no corroborating evidence to show that Mr 3 reported the issues he witnessed to another member of staff or that it was indeed escalated to management. However the panel

had regard to the CQC report of the Home dated 20 December 2017 which clearly details the poor management of the Home at the time of the incident.

The panel considered representations made on your behalf by TBA legal dated 14 March 2018 to the NMC. The panel also considered your statement of defence dated 15 August 2019 and your oral evidence. The panel noted that your response to this charge is a simple denial and that Mr 3 made up these allegations against you as he did not like you.

The panel noted from Mr 3's witness statements that this incident occurred on the first day of his employment at the Home. The panel concluded that Mr 3 would not have known you long enough to hold any sort of animosity towards you. Therefore the panel decided that Mr 3 had no motive to invent any version of events in relation to this charge.

The panel reminded itself that it had found Mr 3 to have been a credible and reliable witness. It considered him to have been clear and consistent in both his documentary and oral evidence in relation to this incident. The panel considered that Mr 3 has been involved in the criminal and the NMC proceedings in relation to this charge. It noted that throughout these protracted proceedings, Mr 3 has maintained his version of events.

The panel accepted the evidence of Mr 3 in preference to yours.

In taking account of the above, the panel was satisfied that, on the balance of probabilities, charge 1a is found proved.

Charge 1b and 1c:

1) While working at Newlands Care Home between 4 February and 8 July 2016:

b) On an unknown date, forcibly administered food to Resident D using a spoon.
c) During the incident in Charge 1(b), above, said to Colleague A "that was how it had to be done as the resident had dementia" or words to the effect.

These charges are found proved.

In reaching this decision, the panel took account of the evidence of Mr 3. The panel noted that Mr 3 was a direct witness to these charges and that charges 1 (b) and (c) relate to the same incident.

In his witness statement to the police, Mr 3 stated '*I was feeding her porridge… Yemi came over to us. Yemi snatched the spoon off me and she rammed a spoon full of porridge in Resident D's closed mouth twice. Yemi said 'that's how you have got to do it… she's got dementia'.*

The panel noted that Mr 3 escalated his concerns to the management but nothing was done about his complaint. The panel had regard to the CQC report for the Home dated 20 December 2017, which supports the fact that at the time of the incident, management were not proactive in dealing with complaints raised.

The panel further considered your simple denial in relation to these charges stating that Mr 3 fabricated these allegations as he did not like you. However the panel preferred Mr 3's evidence to yours.

The panel noted that Mr 3 made his police statement on 11 July 2016 which was closer to the time of the incident. It considered that Mr 3 has been broadly consistent in all his witness statements and whilst giving his oral evidence.

The panel reminded itself that it found Mr 3 to be a credible and reliable witness with regard to his account of the events.

In taking account of the above, the panel was satisfied that, on the balance of probabilities, charges 1b and 1c are found proved.

Charge 1d:

1) While working at Newlands Care Home between 4 February and 8 July 2016:

d) On or around 16 March 2016, conducted a rectal examination of *Resident F without giving prior warning and/or obtaining consent before doing so.*

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Mr 3, your written responses and your oral evidence.

In Mr 3's statements, he details how another colleague alerted you to the fact that Resident F had 'something' they wanted you to see. Mr 3 asked you to come and have a look at Resident F's pad. Mr 3 states '*she rolled him over to his side. She then wrapped a conti wipe around her finger (index or middle finger on her right hand) and inserted it into resident's F's anus. …Yemi inserted her finger for a second time…then inserted her finger for a third time'*.

The panel then went on to consider your response in relation to this charge. It considered written representations by TBA legal on your behalf dated 14 March 2018 which includes your response to the police in relation to this charge. It can be noted that when you were questioned about this incident by the police in June 2016 you denied the allegation stating that the only way you would have carried out a rectal examination was to insert a suppository medication.

In your statement of defence dated 15 August 2019 you gave a different detailed explanation in relation to the incident that gave rise to this charge. In your statement of defence, you detail that another colleague had asked you to attend Resident F as blood

had been seen in his stool. You state that you entered Resident F's room and that no other staff members were in the room with you and you told Resident F that you had come to confirm whether blood was still coming out. Then you stated '*you opened one side* [the pad] *and peeped into back [sic] but there was no blood in the new pad, and I closed it back…'*

The panel noted the detailed response in your statement of defence in relation to this charge. However the panel also noted that whilst giving your oral evidence you did not recount this detailed explanation but repeatedly denied that this incident had happened at all.

The panel accepted the evidence of Mr 3 in preference to yours. The panel found that Mr 3 was very clear and detailed in the sequence of events whilst giving his oral evidence. The panel further found Mr 3 to be broadly consistent in his written and oral evidence.

The panel had regard to the e-mail from the police dated 15 December 2016 which stated '*several witnesses came forward from Newlands which made the following allegations against Yemi'.* The e-mail then goes on to list the allegations relating to force feeding, PR examination and covert medication.

The panel considered that Charges 1 (a) – (d) were subject to criminal proceedings and that you were found not guilty of the charge against you. However the panel noted that there is a different and higher standard of proof in respect of criminal cases than there is in this tribunal.

Taking all the documentary and oral evidence into account, the panel was therefore satisfied that, on the balance of probabilities, Charges 1 (a) – (d) are found proved in their entirety.

Charges 2 and 3

2) *On a date prior to 19 May 2016, submitted an application form for employment as a staff nurse at Moston Grange Care Home without disclosing your previous employment at Newlands Care Home.*

3) On or around 6 September 2016, submitted an application form for employment as a registered nurse at Cale Green Nursing Home, without disclosing your previous employment at Newlands Care Home.

These charges are found proved by way of admission.

Charge 4:

4) Your conduct in Charge 2 and/or Charge 3, above, was dishonest in that you knowingly attempted to conceal that you were the subject of a safeguarding investigation relating to your employment at Newlands Care Home.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 4 and your evidence.

The panel had regard to your evidence in relation to how the Home treated you following your suspension. It took note of your evidence that you were relieved from your duties during a shift and that you were unaware of the reasons for your suspension. The panel also considered your evidence that you only became aware of the reasons for your suspension when you were interviewed by the police. You were subsequently invited by the Home for a probationary meeting and you stated that you were advised by your representative at the Royal College of Nursing to resign rather than be dismissed. As a result you resigned from the Home in July 2016 and did not attend the meeting. Further the panel also considered your evidence that you believed that no further action was to be taken in relation to the police investigation.

You stated that due to your short employment at the Home and the treatment you received whilst employed by them, you completely blocked the Home out of your memory, and this is your reason for failing to disclose that employment to Moston Grange and Cale Green. However, once you were informed of the NMC referral, you immediately informed management at Cale Green on 19 October 2016.

In reaching its decision, the panel had to consider whether your admitted actions in relation to charges 2 and 3 were dishonest.

It took into account of the case of *Ivey v Genting Casinos [2017]* in considering whether you had been dishonest in your actions.

The panel had regard to Ms 4's statement which was agreed and accepted by both parties.

The panel considered your explanation that due to your bad experiences at the Home, the negative effect it had on your life and general wellbeing, you decided to block the Home out of your memory. Further you stated that you had only worked there for a short period of time so you did not think it was necessary to add the Home to your employment history. The panel noted your remorse in respect of your omission and how you have accepted that in the future you will always disclose every employment you have obtained.

The panel did not accept your account and had regard to your inability to give a coherent reason for your actions. The panel noted that whilst giving oral evidence whenever you were asked to give an account for your actions, you deflected from answering the question.

The panel took into account your application forms to Moston Grange and Cale Green and noted that you clearly disclosed information of a long list of other employers, some of which you had worked at for a short period of time, and only the Home was omitted.

The panel also carefully considered your interview notes with Ms 1, Manager of Cale Green. The panel noted your response to the following question:

'Have you had experience of working in this area before (i.e. local to our nursing home)? To see if candidate knows any of our ext contacts' [sic].

You responded: *'sort of Manchester + Didsbury but none in our immediate area of Stockport'.*

The panel considered this statement to be incorrect as you had worked in the Home which was in the same area as Cale Green and this would have been your opportunity to notify Cale Green of your previous employment at the Home if it were an honest omission.

The panel had regard of the meeting notes between you and Ms 1 dated 19 October 2016 following your NMC referral. The panel paid particular attention to the part that stated:

'*I asked Yemi why she had not put Newlands on her application form as an employer – she told me she had only being there a few weeks before this incident. She had been suspended but had then heard nothing, and it dragged on and on'. … Yemi apologised to me at this point saying that she should have logged it on her application form, but was worried she would not get an interview, but she felt she had not done anything and had not had the chance to clear her name'*, which is consistent with Ms 1's oral evidence.

You deny that you had any dishonest motivation for failing to disclose you employment at the Home.

The panel preferred Ms 1's evidence to yours. The panel reminded itself that it found Ms 1 to be a fair and balanced witness. The panel found Ms 1 to be consistent in her witness statement and whilst giving her oral evidence. The panel found Ms 1 to be supportive of you. Ms 1 gave evidence that you were open and honest in relation to the

NMC referral. Ms 1 also gave evidence to support the fact she had not witnessed any concerns with your nursing practice. The panel determined that Ms 1 had no motive to fabricate her version of events particularly as she had always been supportive towards you.

The panel found that your omission to notify Moston Grange and Cale Green of your previous employment at the Home was dishonest.

The panel found that you were not able to give a credible explanation as to why you omitted to disclose your previous employment at the Home to either Moston Grange or Cale Green. On each application form, the panel found that you deliberately failed to disclose the Home as a previous employer. The panel came to the conclusion that your only reason for this was that you were worried that if you disclosed the information you would not get an interview, as documented by Ms 1 in her meeting with you in October 2016. You believed you would not get the job as the Home would disclose your suspension and the circumstances that led to it to prospective employers.

Taking account of all of the above, the panel determined that, on the balance of probabilities, your acts or omissions would be considered to be dishonest by the standards of ordinary, decent people.

Accordingly the panel found the charge proved in relation to both Moston Grange and Cale Green.

Charge 5:

> *5) On one or more occasions between 28 September 2016 and 18 November 2016 while working at Cale Green Nursing Home you provided a drink to Resident G and/or Resident H while they were laying down flat.*
>
> **This charge is found proved (Resident G only)**

In reaching its decision, the panel took account of the evidence of Ms 2 who was a direct witness to this incident. The panel also had regard to the Ms 1's evidence and all the clinical records in relation to this charge.

The panel had regard to Ms 1's evidence in relation to her investigation regarding this incident when she stated '*My own personal view is that the care staff did not like Yemi and did not support her in the way I would expect. I did in fact have to dismiss one of the three carers named in the statement shortly afterwards for inappropriate and racist behaviour that was reported to me'.* The panel noted your evidence that you experienced bullying behaviours whilst employed at Cale Green however the panel did not find that there was sufficient evidence to link this with the incident in Charge 5.

The panel carefully considered the local investigations carried out in relation to this charge. The panel noted that there was no documentary evidence from Cale Green to suggest that these incidents were reported immediately after they occurred.

The panel carefully considered your response in relation to this charge. The panel noted from your written evidence that you simply denied this charge in relation to Resident G and Resident H. When questioned about it during your oral evidence you stated. *"It's not possible for me to do it. For me, I cannot do it. The person is so weak, how can somebody -- I know the expression about choking, and I know the repercussions, I can never… Me personally, I never, I did not do it at all. I never*".

The panel considered Ms 2's oral evidence. The panel noted that Ms 2 was quite defensive when questioned about documenting the incident or escalating the complaint to management level at the time.

The panel had regard to Ms 2's oral evidence in relation to Resident G. When questioned on what she witnessed, she stated as follows:

"*What had happened was on handover we got a report that this lady hadn't had much fluid all day which is not unusual for her but she hadn't had a lot of fluids and would we push fluids at night. … but this lady when she didn't want to drink, she would clamp her*

teeth against the straw. So she would stop you from giving her any more drink, she wouldn't want it… Yemi went in to her. She was -- the lady was on her left-hand side…The bed was obviously -- it was against the wall but you pull it out so you could nurse on both sides of the bed. The brake obviously was on the bed. Yemi was on the -- the lady was facing the wall so Yemi was on the opposite side to her. The lady was on her left-hand side and Yemi was trying to give her a drink as she was lay near enough flat with a straw into her mouth…I followed Yemi in because I knew she was still flat. Not altogether flat but a little flat. And I knew obviously that she -- for her to drink, she needed to be sat up straight because we've always been taught, like I've already said, it can go into their lungs.

…what she did was she tried her hardest to give her a drink. I lifted the bed up. I told her to stop and I lifted the bed up.

… I put the bed up and then Yemi tried to give her a drink with the straw. She wouldn't have it, she was clamping it so there was no point. I pulled the bed out and I asked Yemi to go round the other side so she would be facing the lady to give her a drink, try that way".

The panel noted that Ms 2 was clear and concise in the sequence of events in relation to Resident G. This was consistent with the account detailed in Ms 1's contemporaneous notes of her interview with Ms 2 dated 1 December 2016. It was also consistent with Ms 2's police witness statement dated 18 January 2017. The panel noted that these two statements were made closer to the time of the incident.

The panel found that Ms 2 was able to articulate what happened in relation to Resident G.

The panel reminded itself that it found Ms 2's oral evidence to be largely credible and reliable in relation to the events she witnessed, and that it had also found her to have a good recollection of what she had witnessed. Taking all of the evidence into account the panel found that on the balance of probabilities you provided a drink to Resident G whilst Resident G was laying down flat.

However the panel decided that it lacked sufficient and reliable evidence in relation to you providing Resident H with a drink whilst laying down flat.

The panel noted that the evidence in support of Resident H was a hearsay account of what Ms 1 was reportedly told by a colleague.

Further the panel had regard to Ms 2's oral evidence in relation to Resident H and her police witness statement. When cross examined in relation to Resident H, Ms 2 stated as follows:

"What happened was if you let me tell you, the gentleman that you're talking about, this is the second gentleman you're talking about with the flat bed --…

Sorry, yes. The gentleman had a flat bed and obviously we lifted the bed up. I told Yemi to lift the bed up, the back rest so the gentleman was sat up. That was the second one. That's not the first one that I helped her with…

However in Ms 2's police witness statement dated 18 January 2017, Ms 2 stated *'as I walked pass Resident H room, I saw Yemi was in there giving him a drink and his bed was flat. I then walked passed and went into the next residents room'. [sic]*

Even though Ms 2 was consistent in her evidence that she saw you give two residents drink whilst they were laying down flat, the panel noted that there were inconsistencies in Ms 2's oral evidence and her police witness statement as to the sequence of events.

Due to the inconsistent evidence of Ms 2 and the fact that the initial evidence in relation to Resident H was based on hearsay, the panel decided that it did not have reliable evidence to find this charge proved in relation to Resident H.

Accordingly this charge is found proved in relation to Resident G only.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of the resumed hearing on 2 March 2020 that Mrs Ipadeola was not in attendance and that the Notice of Hearing letter had been sent to Mrs Ipadeola's registered address by recorded delivery first class post on 2 January 2020. This letter was collected from Manchester North East Customer Service Point on 6 January 2020 and signed for by *"IPADEOLA"*. Notice of this hearing was also sent to Mrs Ipadeola's representative, Dr Taiwo of TBA Legal, in a letter dated 2 January 2020.

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

The panel accepted the advice of the legal assessor who reminded the panel that as this is an adjourned hearing, the rule that applies is Rule 32 (3) of the Rules which states as follows:

> ***32.*** *— (3) Where the proceedings have been adjourned, the Practice Committee shall, as soon as practicable, notify the parties of the date, time and venue of the resumed hearing.*

The panel took into account that the Notice of Hearing provided details of the resumed hearing, the time, date and venue of the hearing and had been sent to Mrs Ipadeola's registered address two months before the actual hearing.

In the light of all of the information available, the panel was satisfied that Mrs Ipadeola has been served with the Notice of Hearing in accordance with the requirements of Rule 32.

Decision and reasons on proceeding in the absence of Mrs Ipadeola

The panel next considered whether it should proceed in the absence of Mrs Ipadeola. The panel had regard to Rule 21(2), which states:

*‘**21.**— (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—*

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.’

Ms Woolfson invited the panel to continue in the absence of Mrs Ipadeola on the basis that she had voluntarily absented herself. Ms Woolfson drew the panel’s attention to correspondence from Mrs Ipadeola’s representative Dr Taiwo which at all times were copied to Mrs Ipadeola’s registered e-mail address.

Ms Woolfson submitted that Mrs Ipadeola, via Dr Taiwo, has indicated that she has disengaged from the proceedings. She submitted that following this correspondence from Dr Taiwo in January 2020, there had been no engagement at all by Mrs Ipadeola with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

Ms Woolfson submitted that Mrs Ipadeola, via her representative, has always expressed her displeasure as to what she has considered to be protracted proceedings. At this stage of the proceedings, she submitted that it will be in the interest of all parties for the hearing to proceed in the absence of Mrs Ipadeola.

The panel accepted the advice of the legal assessor who, amongst other case law, included reference to the case of *R. v Jones (Anthony William), (No.2) [2002] UKHL 5.*

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

The panel noted the correspondence dated 13 January 2020 from Mrs Ipadeola's representative Dr Taiwo, which states:

'*Mrs Oluyemi Ipadeola has instructed us to place you on notice that, she will not be attending either of the resumed hearings scheduled to hold in February and March 2020, as according to her, such hearings were unnecessary particularly since a substantive hearing, where facts, evidence, examinations and submissions had been held in August 2019, and where there had been adjournment in order to consider the panel's decision. …Mrs Oluyemi Ipadeola will be content with the panel arriving with its decision on the basis of the information before it, including TBA Legal's "Summary..." currently in possession of the NMC and without having to expend further time, energy and money…'.*

This position was further reiterated in an e-mail dated 23 January 2020 by Mrs Ipadeola's representative which states:

'*As you were already notified of Mrs Oluyemi Ipadeola's reasonable decision not to make herself present at any future hearings scheduled by the NMC, particularly those scheduled for the months of February and March 2020.*
… Mrs Oluyemi Ipadeola and ourselves shall eagerly be looking forward to receiving the outcomes/decisions of the scheduled hearings please'.

The panel noted that this correspondence was also forwarded to the e-mail address contained in the NMC's register, which was confirmed by Mrs Ipadeola whilst giving oral evidence as being her e-mail address.

The panel also noted that Mrs Ipadeola has not responded to any of the NMC correspondence offering her an opportunity to engage and alternative ways to participate with the proceedings. The panel also noted that the NMC attempted to contact Mrs Ipadeola and her representative via telephone and email on the day of the hearing. These attempts were also unsuccessful. The panel therefore came to the conclusion that Mrs Ipadeola has voluntarily absented herself.

The panel has decided to proceed in the absence of Mrs Ipadeola. In reaching this decision, the panel has considered the submissions of the case presenter, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *Jones*. It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Ipadeola;
- Mrs Ipadeola has not engaged with the NMC since 23 January 2020 and has not responded to any of the letters, telephone calls or e-mails sent to her about this hearing;
- Mrs Ipadeola has indicated that she has disengaged from these proceedings, through her representative Dr Taiwo of TBA legal and indicated that she is satisfied for the panel to make a decision based on her oral evidence and the documentary evidence currently before it. The panel therefore considered that there is no reason to suppose that adjourning would secure her attendance at some future date;
- The charges relate to events that occurred in 2016;
- It is in the interest of all parties especially Mrs Ipadeola who has expressed her displeasure via her representative at the length of these proceedings, to dispose of this case as soon as possible.
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Ipadeola.

Fitness to practise:

Having found the facts proved, the panel then considered whether the facts amount to misconduct and, if so, whether Mrs Ipadeola's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submission on misconduct and impairment:

In her submissions, Ms Woolfson invited the panel to take the view that Mrs Ipadeola's actions amount to a breach of *The Code: Standards of conduct, performance and ethics for nurses and midwives 2015* ("the Code"). She then directed the panel to specific paragraphs and identified where, in the NMC's view, Mrs Ipadeola's actions amounted to misconduct, specifically 1.2, 4.2, 8.2, 20.1, 20.2, 20.3, 20.5 and 20.8.

Ms Woolfson referred the panel 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.'*

Ms Woolfson submitted that the failure of Mrs Ipadeola to safeguard vulnerable patients, communicate effectively with her colleagues, her non-disclosure to prospective

employers and her associated dishonesty were a serious departure from the Code and what is expected of Mrs Ipadeola as a registered nurse.

Ms Woolfson submitted that the charges individually and cumulatively were serious enough to amount to misconduct.

She then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Ms Woolfson referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)*. She submitted that the panel should find that all limbs in the case of Grant are engaged.

Ms Woolfson submitted that the question for the panel is whether Mrs Ipadeola's fitness to practise is impaired as of today's date.

Ms Woolfson submitted, in some circumstances, that Mrs Ipadeola's misconduct in relation to her patient care would be potentially remediable. She submitted that the misconduct occurred in the course of clinical practice and it is possible to carry out targeted specific training to demonstrate that the clinical failings have been addressed.

However, Ms Woolfson submitted that the panel have nothing before it to show that Mrs Ipadeola has remediated her clinical failings. She submitted that even though Mrs Ipadeola denies the charges in relation to her clinical failings, she could have undergone some training to show her willingness to address the issues that gave rise to the regulatory concerns. However, she has failed to do this.

In relation to insight, Ms Woolfson submitted that there is nothing before the panel that indicated that Mrs Ipadeola has shown insight into her clinical failings. She submitted that in the evidence before the panel, Mrs Ipadeola has not been able to explain why the clinical failings occurred but instead simply denied the charges. Ms Woolfson submitted that these clinical failings occurred over a period of 10 months and in two

different places of employment and as such, the panel cannot be satisfied that there is no risk of repetition. Ms Woolfson then submitted that the evidence in relation to Charges 1b, 1c and 5 included behaviours in front of, or towards, junior members of staff, demonstrating a disregard for her duties as a registered nurse to role model in her practice, amounted to an attitudinal issue.

Ms Woolfson submitted that to Mrs Ipadeola's credit she admitted Charges 2 and 3 and apologised for her actions in relation to these charges. However Mrs Ipadeaola continued to deny the dishonesty in relation to these charges (charge 4) which has now been found proved by the panel. Ms Woolfson submitted that Mrs Ipadeola's continual denial of charge 4 (which has been found proved by the panel) and the fact that dishonesty issues are difficult to remediate, means that there is still a risk of repetition in relation to the dishonest conduct. Therefore Ms Woolfson invited the panel to reach a finding of impairment on public protection grounds.

Ms Woolfson submitted that a finding of impairment should also be found on public interest grounds in order to declare and uphold the professional standards expected of a registered nurse, and to maintain public confidence in the profession and the NMC as regulator.

The panel accepted the advice of the legal assessor, who referred it to the relevant legal principles, including those set out in cases of *Cohen* [2008] EWHC 581 and *Grant*.

Decision on misconduct:

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of <u>The Code: Professional Standards of practice and behaviour for nurses, midwives and nursing associates 2015 ("the Code")</u>.

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Mrs Ipadeola's actions did amount to a breach of the Code as follows:

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.5 respect, support and document a person's right to accept or refuse care and treatment, and …

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action.

8 Work cooperatively

To achieve this, you must:

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

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

To achieve this, you must:

> 9.4 support students' and colleagues' learning to help them develop their professional competence and confidence.

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other healthcare professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to…

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel decided that Mrs Ipadeola's actions in charges 1 (a) – (d), and 5 (in relation to Resident G only), involved patient harm and multiple, serious and similar clinical failings in two Residential Homes and occurred over a 10 month period.

The panel further considered that Mrs Ipadeola's actions in charges 2, 3 and 4 were serious and premediated acts of dishonesty committed at two Residential Homes in order for Mrs Ipadeola to gain employment. These dishonest acts involved a breach of

trust and a breach of her duty of candour in Mrs Ipadeola’s failure to be open and transparent with her prospective employers.

The panel further considered that the behaviour noted in Charges 1 and 5 took place in front of junior members of staff which, combined with the dishonesty, demonstrated attitudinal issues.

The panel found that Mrs Ipadeola’s actions in all the charges, individually and collectively did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

It is paramount that registered nurses must always act with integrity and uphold the reputation of the profession. The panel was in no doubt that Mrs Ipadeola’s conduct was of the kind that other nurses would consider deplorable.

Having concluded that Mrs Ipadeola’s behaviour amounted to misconduct, the panel moved on to consider whether, on the basis of the facts found proved, her fitness to practise is currently impaired by reason of her misconduct.

Decision and reasons on impairment:

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) 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".

Mrs Justice Cox went on to say in Paragraph 76:

"I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

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

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

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

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

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

The panel finds that limbs a, b, c and d are engaged in this case.

The panel decided that Mrs Ipadeola's conduct, individually and collectively, brought the profession into disrepute and breached a fundamental tenet of nursing by failing to provide a high and appropriate standard of practice and by failing to uphold the reputation of the profession.

With regard to assessing the future and any risk that Mrs Ipadeola may pose, the panel considered the questions posed in the case of *Cohen*, namely whether Mrs Ipadeola's misconduct is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated.

The panel gave careful consideration to Mrs Ipadeola's oral evidence, her statement of defence and all the evidence before it.

The panel noted that this is the first regulatory concern following Mrs Ipadeola's service as a nurse for over 31 years in Jamaica, Nigeria and the UK.

The panel carefully considered whether Mrs Ipadeola has expressed genuine remorse. The panel noted that Mrs Ipadeola has only apologised for her admitted actions in Charges 2 and 3. The panel found that Mrs Ipadeola chose to disengage from the regulatory process and the panel considered that it has nothing before it to show that Mrs Ipadeola has expressed genuine remorse in relation to all the other charges found proved. From the outset, Mrs Ipadeola has maintained her simple denial in relation to her clinical failings and her dishonesty without any further elaboration and without any apologies.

Regarding insight, the panel found that from the oral and documentary evidence before it, Mrs Ipadeola has not shown insight. The panel considered that it did not have any reflective piece from Mrs Ipadeola before it, even in relation to the admitted charges. The panel noted that Mrs Ipadeola has not provided evidence to demonstrate her understanding of the effect her actions had or could have had on patients and/or their families. It further considered that Mrs Ipadeola has not demonstrated her

understanding of how her actions affected or could have affected her colleagues, the wider profession and the public perception of nursing.

The panel considered that the clinical failings identified in this case are serious as they involved patient harm and safeguarding of vulnerable adults.

The panel noted that even though Mrs Ipadeola is currently allowed to practise with conditions as a registered nurse, there is no evidence before it to suggest that she has continued to practise as nurse in a clinical setting. The panel noted that it had no documentary evidence before it that Mrs Ipadeola has attempted to remediate any of her serious clinical failings. The panel decided that there is no evidence before it that Mrs Ipadeola has demonstrated that she has kept her knowledge and skills up to date.

The panel is of the view that the serious conduct in relation to the clinical failings identified in this case is potentially remediable but it has not been remedied.

The panel recognised that dishonesty is difficult to remediate. However, the panel is of the view that there is a serious risk of repetition in relation to all the charges found proved due to Mrs Ipadeola's complete lack of insight and complete lack of remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of that profession. The panel determined that, in this case, a finding of impairment on public interest grounds was required as a fully informed member of the public would be greatly concerned by the clinical failings and dishonest acts of Mrs Ipadeola.

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

Determination on sanction:

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

In reaching this decision, the panel has had regard to all the evidence that has been presented in this case. The panel accepted the advice of the legal assessor. 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) published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

Ms Woolfson informed the panel that the sanction bid for this case was that of a striking-off order. She submitted what the NMC perceived to be the aggravating factors and likely mitigating factors of the case.

The panel considered the following to be aggravating factors in the case:

- Mrs Ipadeola's actions involved patient harm in relation to charge 1.
- Mrs Ipadeola put vulnerable patients in her care at risk on more than one occasion.
- Mrs Ipadeola's poor standard of basic and fundamental nursing care.
- Mrs Ipadeola's undermining of safeguarding procedures for the vulnerable patients in her care.
- Risk generated by Mrs Ipadeola as a registered nurse by setting a poor example of patient care to new and junior members of staff in charges 1 and 5.
- Mrs Ipadeola's repeated dishonesty.
- The dishonesty was solely for Mrs Ipadeola's own financial gain.
- Mrs Ipadeola undermining safeguarding procedures in relation to charges 2, 3 and 4 as her non-disclosure and dishonest conduct did not give her prospective

employers the opportunity to manage and mitigate the risk of any potential patient harm.

- Mrs Ipadeola's lack of demonstrable insight.
- The pattern of misconduct was over a period of 10 months.

The panel decided that the mitigating factors in Mrs Ipadeola's case are as follows:

- Mrs Ipadeola's early admissions to charges 2 and 3
- [PRIVATE]
- Mrs Ipadeola's positive testimonials

The panel had regard to the NMC guidance entitled "Considering sanctions for serious cases" and especially the section relating to cases involving dishonesty. The panel determined that this case fell at the higher end of the spectrum of dishonesty and included the following factors:

- vulnerable victims
- personal financial gain…
- direct risk to patients
- premeditated, systematic or longstanding deception

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.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate where *'…the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise committee wants to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Ipadeola's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Ipadeola'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.

The panel is of the view that there are no practical or workable conditions that could be formulated in relation to the dishonesty charge in this case. Further, it took into account Mrs Ipadeola's lack of insight, remediation, remorse and current lack of engagement and noted that it therefore had no information that could assist it in reaching a conclusion that Mrs Ipadeola would engage with any conditions that were put in place. The panel also found that Mrs Ipadeola's conduct in relation to her clinical failings and dishonesty were indicative of attitudinal issues, which are difficult to address with conditions of practice.

The panel concluded that the placing of conditions on Mrs Ipadeola's registration would not adequately address the seriousness of this case, particularly the aspect of dishonesty, and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG indicates that a suspension order would be appropriate where (but not limited to):

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

The panel had regard to the fact that Mrs Ipadeola's actions involved patient harm. It noted that Mrs Ipadeola repeated her dishonesty, which showed attitudinal problems, and her actions occurred over a 10 month period.

It is the view of the panel that Mrs Ipadeola's actions represent a clear attitudinal issue. Her unsafe and poor nursing practice had been highlighted to her by colleagues and a safeguarding investigation was commenced by her employers as a result of her failings. Yet rather than accept there must be an issue, Mrs Ipadeola did not disclose her employment at the Home to prospective employers, in an attempt to conceal her safeguarding investigation and failings. She applied for new registered nursing jobs at Cale Green and Moston Grange, where these failings could again impact on the safety and wellbeing of patients.

Further, it was the panel's view that Mrs Ipadeola had demonstrated no insight into her actions.

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. A suspension order could not adequately protect the public taking into account Mrs Ipadeola's lack of insight and does not satisfy the public interest, considering the seriousness of the charges.

Finally, in considering a striking-off order, the panel took note of the following from the SG:

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

The panel decided that Mrs Ipadeola's actions demonstrated attitudinal issues which showed a lack of care for vulnerable patients, putting them at serious risk of harm, and also involved repeated attempts to deceive her employers.

Mrs Ipadeola's attitude is considered by the panel to be fundamentally incompatible with the attitudes and behaviours expected of a registered nurse, who must at all times seek

to protect patients from risks of harm including those posed by their own nursing abilities. The panel considered that all three tests as set out above are met.

Further, Mrs Ipadeola's behaviour showed disregard for the fundamental tenets of nursing including integrity, trust and honesty.

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

The panel was aware that the effect of a striking-off order is likely to involve financial hardship. However the panel was satisfied that any such hardship is outweighed in this case by the need to protect the public and uphold the public interest.

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

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

Determination on Interim Order

The panel has considered the submissions made by Ms Woolfson that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.