Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
09-13 November 2020

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

Name of registrant:	Sunday Olubode Fatola
NMC PIN:	97C1145O
Part(s) of the register:	Sub Part 1 RN1: Adult Nurse (1 April 2000)
Area of registered address:	Bristol
Type of case:	Misconduct
Panel members:	Irene Kitson (Chair, Lay member) Martin Bryceland (Registrant member) Rachel Childs (Lay member)
Legal Assessor:	Michael Hosford-Tanner
Panel Secretary:	Roshani Wanigasinghe
Nursing and Midwifery Council:	Represented by Robert Rye, Case Presenter
Mr Fatola:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 6 and 8
Facts not proved:	Charges 4, 5, 7 and 9
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order – 18 months

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Fatola was not in attendance and that the Notice of Hearing letter had been sent to Mr Fatola's registered address by recorded delivery and by first class post on 22 September 2020.

The panel had regard to the Royal Mail 'Track and Trace' printout which showed the Notice of Hearing was delivered to Mr Fatola's registered address on 24 September 2020. It was signed for against the printed name of 'FATOLA'.

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

Mr Rye, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Fatola has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Fatola

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

Mr Rye referred the panel to the documentation from Mr Fatola which included emails and telephone notes which state Mr Fatola is content for hearing to proceed in his absence.

Mr Rye referred the panel to a telephone note dated 6 October 2020 between the NMC and Mr Fatola where it was stated:

> "SF [Mr Fatola] confirmed receipt of NMC correspondence but this as well as other NMC correspondence was not opened but placed on a pile. From speaking with SF he has clearly had enough of the process and would like matters to proceed in his absence as this has been on-going for 2 years+".

Mr Rye further referred the panel to another telephone note dated 23 October 2020 where it was stated

> "SF confirmed he would like this case to go ahead in his absence in November 2020 and matters resolved once and for all."

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mr Fatola. In reaching this decision, the panel has considered the submissions of Mr Rye, the information before it regarding Mr Fatola's positon and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Fatola;
- Mr Fatola has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses are ready to give remote evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Fatola in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give oral evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Fatola's decision to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In taking account of all the above, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Fatola. The panel will draw no adverse inference from Mr Fatola's absence in its findings of fact.

Details of charges (amended)

That you, a registered nurse:

1) Between 01 July 2017 and 31 July 2017 left medication unattended on a tray within an unlocked clinic room. **[This charge is found proved]**

2) On 08 March 2018 administered Apixaban to Resident A when Resident A's prescription for Apixaban had been placed on hold for 48 hours.
[This charge is found proved]

3) Between 26 August and 27 August 2018;

a) Having been informed by a healthcare assistant colleague A that Resident B's catheter was bypassing, failed to take adequate action to deal with the concern.
[This charge is found proved]

b) Administered medication without the use of the drug trolley and medication administration record charts. **[This charge is found proved]**

c) Being the sole qualified nurse on night duty, slept on one or more occasions during the shift. **[This charge is found proved]**

4) On 26 August 2018 at 23:06 failed to respond to a call for assistance from Resident B **[This charge is found NOT proved]**

5) On 27 August 2018 at 03:52 and 07:34 failed to respond to calls for assistance from Resident B. **[This charge is found NOT proved]**

6) On 6 September 2018 during a formal disciplinary meeting, told the registered home manager colleague B that you had checked on Resident B on more than 1 occasion

during the night shift of 26 – 27 August 2018. **[This charge is found proved]**

7) Your action in charge 6 above were dishonest in that you knew you had not checked Resident B on more than 1 occasion during the night shift of 26 – 27 August 2018. **[This charge is found NOT proved]**

8) On 6 September 2018 during a formal disciplinary hearing, told the registered home manager colleague B that Resident B had called you at 05:00 on 27 August 2018. **[This charge is found proved]**

9) Your actions in charge 8 above were dishonest in that you knew Resident B had not called you at 05:00 on 27 August 2018. **[This charge is found NOT proved]**

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

Decision and reasons on application to admit telephone or video link evidence for Resident B

The panel heard an application made by Mr Rye under Rule 31 and 23 to allow Resident B to give his evidence over the telephone. Mr Rye informed the panel that Resident B was not present at this hearing and explained he is severely disabled physically and in those circumstances to allow his evidence to be provided via telephone. It was submitted that telephone rather than video evidence would respect Resident B's disability and dignity.

The panel gave the application in regard to Resident B serious consideration. The panel noted that Resident B's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by the Clinical Lead on his behalf.

The panel considered Resident B's health condition and it was of the view that it was fair and reasonable in the particular circumstances of Resident B to hear his evidence via telephone. It decided that it would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Application under Rule 31 for evidence via video link:

Mr Rye further made an application for the witnesses, Colleague A, Colleague B and Colleague C to give evidence via video link. The application was made under Rule 31 of The Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (as amended) (the Rules). He submitted that all three witnesses are prepared to give evidence, however, due to the current Covid-19 restrictions, it would be difficult to attend in person. Mr Rye further submitted that this hearing is not one where their demeanour needs to be tested and thus hearing their evidence via video link would not significantly diminish the quality of their evidence.

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

The panel considered that, given the current Covid-19 restrictions and that there is currently a lockdown rather than simply the circumstances of the pandemic, it would be fair to allow Colleague A, Colleague B and Colleague C to give evidence via video link. The witnesses would be able to be seen and their demeanour assessed adequately. The panel did not accept that the demeanour of the witnesses is irrelevant. The panel further considered that hearing their evidence would assist the panel in conducting a fair hearing. In these circumstances, the panel came to the view that it would be fair and appropriate to allow Colleague A, Colleague B and Colleague C to give evidence remotely via video link, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The NMC received a referral from Hazelwood Gardens Nursing Home ("the Home") in Bristol regarding Mr Fatola who was employed as a Registered General Nurse on night duties since 12 October 2016.

On 26 August 2018 Mr Fatola worked a 12 hour night shift which started at 20:00. He was the sole registered nurse on the shift.

It is alleged that he had been asked by Health Care Assistants (HCAs) to look at Resident B's catheter as it appeared to be blocked causing the catheter to bypass leaving Resident B wet with urine. Mr Fatola had allegedly said that he checked the catheter at around 23:00 and although the catheter had not drained much urine Resident B was comfortable and the catheter site was dry (suprapubic). Mr Fatola had also said that he had checked Resident B again at 01:35 and "he was sleeping and comfortable" although Mr Fatola said that he only listened at Resident B's door and did not enter the room. It is alleged by the referrer that the CCTV footage does not show that Mr Fatola left the office to go and see Resident B.

When Mr Fatola handed over to day staff, the day nurse had asked why he had not re-catheterised Resident B. Mr Fatola had stated that he was not trained to do so and that he did not want to ring management for advice because it was late at night. It was also noted on the CCTV that when Mr Fatola did the medication round he did not use the medication trolley or consult with the MAR charts and was therefore not following the Home's policies and procedures.

Mr Fatola was suspended from duty from the next shift and a disciplinary meeting was held on 6 September 2018.

Decision and reasons on the NMC application to amend the charges

The panel heard an application made by Mr Rye to amend the wording of charges 2, 3, 6 and 8.

Mr Rye submitted that in relation charge 2, the amendment is to the name of the medication, “Apixaban”, which has been spelt incorrectly in the original charge. He submitted in relation to charge 3 the proposed amendment is to include both dates “Between the 26 and 27 August 2018” rather than the original charge which stated just the one day of 26 August 2018. He submitted that the proposed inclusion of both dates is to correctly reflect the night shift duty Mr Fatola was on. Finally, he submitted that in relation to charges 6 and 8, the proposed amendment would be to add “incorrectly” to both charges. He submitted that doing so would provide clarity and thereby resolve current deficiencies in the charges.

Current charges 2, 3, 6 and 8:

“2) On 08 March 2018 administered Aprixaban to Resident A when Resident A’s prescription for Aprixaban had been placed on hold for 48 hours.

3) On 26 August 2018;

a) Having been informed by a healthcare assistant colleague A that Resident B’s catheter was bypassing, failed to take adequate action to deal with the concern.

b) Administered medication without the use of the drug trolley and medication administration record charts.

c) Being the sole qualified nurse on night duty, slept on one or more occasions during the shift.

6) On 6 September 2018 during a formal disciplinary meeting, told the registered home manager colleague B that you had checked on Resident B on more than 1 occasion during the night shift of 26 – 27 August 2018.

8) On 6 September 2018 during a formal disciplinary hearing, told the registered home manager colleague B that Resident B had called you at 05:00 on 27 August 2018."

Proposed amendment to charge 2, 3, 6 and 8:

"2) On 08 March 2018 administered Apixaban to Resident A when Resident A's prescription for Apixaban had been placed on hold for 48 hours.

3) Between 26 August and 27 August 2018;

a) Having been informed by a healthcare assistant colleague A that Resident B's catheter was bypassing, failed to take adequate action to deal with the concern.

b) Administered medication without the use of the drug trolley and medication administration record charts.

c) Being the sole qualified nurse on night duty, slept on one or more occasions during the shift.

6) On 6 September 2018 during a formal disciplinary meeting, incorrectly told the registered home manager colleague B that you had checked on Resident B on more than 1 occasion during the night shift of 26 – 27 August 2018.

8) On 6 September 2018 during a formal disciplinary hearing, incorrectly told the registered home manager colleague B that Resident B had called you at 05:00 on 27 August 2018."

Mr Rye submitted that the proposed amendments would not cause any unfairness or injustice to Mr Fatola. He submitted that the technical nature of the proposed changes does not change the substantive meaning of the charges that were sent to Mr Fatola.

In response to a question raised by the panel that there may be some injustice caused to Mr Fatola considering he does not now know the proposed amendments to charges 6 and 8, Mr Rye submitted that the panel may on its own motion decide to adjourn the hearing and invite Mr Fatola to provide a response if it deems it necessary. He submitted however, that the NMC is not requesting an adjournment of this case as it remains the positon that the proposed amendments do not cause any unfairness or prejudice to Mr Fatola.

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

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

The panel carefully considered the merits of Mr Fatola's case and whether any unfairness would result if amendments to the charges were made.

The panel noted that the proposed amendment related to charges 2, 3, 6, and 8.

The panel considered the first proposed amendment to correct the word “Apixaban”. The panel noted that this was merely a correction of the spelling of the medication and therefore accepted this amendment.

The panel went on to consider the proposed amendment to charge 3. The panel noted that the inclusion of the words “Between 26 August and 27 August 2018” reflects the night shift Mr Fatola was on more accurately. The panel therefore accepted this amendment.

The panel next considered the proposed amendments to charges 6 and 8. It carefully considered these amendments on the merits of the case and whether it would create any injustice to Mr Fatola. The panel considered that it is not necessary to add the word “incorrectly” to charges 6 and 8 because the alleged incorrectness of the statements is implicit in the allegation of dishonesty within the wording in each of charges 7 and 9. On this basis, the panel rejected the proposed amendments to charges 6 and 8.

Decision and reasons on facts

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

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

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:

- Resident B: A resident in the Home

- Colleague A: Health Care Assistant (HCA) at the Home
- Colleague B: Registered Manager at the Home
- Colleague C: Deputy Manager at the Home

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

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

Resident B: The panel considered the evidence of Resident B to be honest, credible and reliable. Resident B did not seek to embellish any of the details. The panel was of the view that he was careful to say what he did remember of the events and answered questions that were asked of him in a thoughtful way and to the best of his abilities. The panel noted there were some discrepancies between his evidence and that of other witnesses, but the panel gave strong weight to his evidence. The panel also bore in mind the passage of time since these events occurred. Resident B was genuine and admitted when he could not remember certain details.

Colleague A: The panel considered the evidence of Colleague A to be credible and reliable. The panel noted that Colleague A was nervous but attempted to assist the panel to the best of her abilities. She limited her evidence to what she remembered and did not seek to exaggerate the evidence. The panel noted some minor discrepancies in her evidence on timings and chronology, but was of the view that this was due to the passage of time.

Colleague B: The panel considered the evidence of Colleague B to be credible and reliable in the main. It noted that much of Colleague B's evidence was limited to a review of CCTV footage. The panel noted that she was not present during the incidents and was only present during the disciplinary meeting. The panel accepted that Colleague B had attempted to do a thorough review of the CCTV footage, however, she stated that she only focused on Mr Fatola whilst watching the footage and therefore her evidence of the CCTV was of limited value. It was apparent that her record of the CCTV footage omitted a significant event at about 22:30 to which two other witnesses referred. Therefore, her evidence of the CCTV footage was of limited value except where the panel was directed to specific CCTV footage.

Colleague C: The panel was of the view that Colleague C provided concise evidence. The panel noted that Colleague C provided oral evidence consistent with her witness statement. The panel considered that Colleague C relied heavily on her memory concerning the charges in relation to Resident B, which also included conversations with Colleague A and E. Those conversations were not recorded and she took no notes. All of these events occurred shortly before she went on holiday, which meant she took no further part in any of the internal investigations. Colleague C's evidence also contradicted Resident B's evidence where he said that he had no particular overall complaints about how Mr Fatola performed his duties. The panel found some confusion in her written evidence which it had to seek to clarify in her oral evidence. However, she gave a clear account of the matters in charge 1.

Charge 1

> "Between 01 July 2017 and 31 July 2017 left medication unattended on a tray within an unlocked clinic room."

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague C.

The panel noted the witness statement of Colleague C dated 23 March 2019 where she states:

> "I am unable to recall the exact date this took place. I had come into the Home early at approximately 05.45 hours and walked into the nurses' office to find a little tray with I think three medication pots on it…I stayed at the nurses' office and Sunday returned a few minutes later. When he came in I gestured to the tray an asked him what that was, Sunday told me that he had put the tray there because the resident had been on their way down to the ground floor to receive medication...I reported it to [Colleague B] but do not know what action she took in response."

The panel took into account the passage of time in relation to Colleague C's evidence. It also noted that Colleague C asserts that it was reported to Colleague B and that she had no further dealings with it. However Colleague B makes no reference to any previous disciplinary issues concerning Mr Fatola.

The panel accepted Colleague C's evidence. It found Colleague C's account to be clear. It bore in mind her position as a registered nurse and the responsibilities she holds. It was of the view that there was no reason why she would attempt to lie about this matter. Mr Fatola will have read her statement and had not challenged it. Although the panel did not have any other supporting evidence before it, it was of the view that on the balance of probabilities, between 01 July 2017 and 31 July 2017, Mr Fatola left medication unattended on a tray within an unlocked clinic room.

In light of the above evidence, the panel found this charge, on the balance of probabilities, proved.

Charge 2

> "On 08 March 2018 administered Apixaban to Resident A when Resident A's prescription for Apixaban had been placed on hold for 48 hours."

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague B and Mr Fatola's handwritten statement dated 08 March 2018.

The panel noted that Colleague B in her written statement dated 19 March 2019 stated:

> "Resident A had been due to attend the hospital that day to have her dialysis stent re-sited. She told me that 'Sunshine', which is what she called Sunday, had made her take her [sic] all her tablets the previous morning…. but Sunday had made her take all the medicines that she was due that morning."

The panel accepted this evidence and there is documentation showing that the medication had been administered to Resident A by Mr Fatola as evidenced by the MAR chart.

The panel then had sight of Resident A's pre-op assessment form where it states:

> "Apixaban-last dose to be taken on morning of 07/03/18- omit for 48 hours prior to surgery"

The panel took this information as evidence that this medication should not have been administered to Resident A on that occasion.

Within Mr Fatola's handwritten statement dated 08 March 2018, Mr Fatola had stated:

"…I told her that I will give her all her medicine as planned and reviewed. I gave her all her morning medicines including APIXABAN…"

The panel concluded that it had sufficient evidence before it to conclude that on 8 March 2018, Mr Fatola administered Apixaban to Resident A when Resident A's prescription for Apixaban had been placed on hold for 48 hours.

In light of the above evidence, the panel found this charge, on the balance of probabilities, proved.

Charge 3a

"Between 26 August and 27 August 2018;

Having been informed by a healthcare assistant colleague A that Resident B's catheter was bypassing, failed to take adequate action to deal with the concern."

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Colleague B, the disciplinary meeting notes provided by Colleague C and a handwritten version of which had been signed by Mr Fatola.

The panel has noted and accepted the evidence of colleague A that Mr Fatola attended on Resident B and checked his catheter at about 22:30 in the company of Colleague A and E.

The panel heard and read the evidence of Colleague C who stated that Mr Fatola should have checked Resident B between 22:30 and the end of his shift at 08:00. The panel noted in particular that Colleague C said in her oral evidence that she "would have expected Mr Fatola to check on Resident B frequently, have expected him to check on the

catheter and if necessary to reposition it, undertake a bladder washout and finally call for help if these didn't work."

The panel further noted that in Colleague C's written statement dated 23 March 2019 in which she stated "I would expect the nurse to check on the client at least hourly to see if everything was alright." In oral evidence, College C stated that a nurse's expertise was required to carry out the checks adequately at some stage during the rest of the shift.

The panel noted that Mr Fatola had said during his disciplinary meeting that he went in to check on Resident B once between 22:30 and 08:00 but he did not make a note of it. In his written internal statement of 3 September 2018, he had said that when he was going around the floors at 01:35, he noticed that Resident B was settled and asleep. The panel further noted that during this disciplinary meeting, he had claimed that "he listens [sic] at the door". It was recorded in the disciplinary meeting notes dated 6 September 2018 that Colleague B had stated that there was no evidence of Mr Fatola at Resident B's door when she reviewed the CCTV footage, to which Mr Fatola had said he used the stairs.

The panel noted that Colleague B within this meeting reiterated to Mr Fatola that there is no evidence of him being at the door, although Mr Fatola maintained his position.

The panel was of the view that given the underlying medical conditions of Resident B and his particular susceptibility to the implications of a blocked catheter, Mr Fatola had a specific duty to monitor the catheter in the course of providing adequate care. The panel was of the view that even if Mr Fatola had listened at the door, this would not be adequate care as a registered nurse's actual observations and checks of Resident B was needed.

Therefore on the balance of probabilities the panel was of the view that Mr Fatola, having been informed by a healthcare assistant Colleague A that Resident B's catheter was bypassing, failed to take adequate action to deal with the concern, by monitoring and checking adequately over the remainder of the night shift.

In light of the above evidence, the panel found this charge, on the balance of probabilities, proved.

Charge 3b

> "Between 26 August and 27 August 2018;
>
> > Administered medication without the use of the drug trolley and medication administration record charts."

This charge is found proved.

In reaching this decision, the panel took into account the CCTV evidence and Mr Fatola's disciplinary meeting notes dated 6 September 2018 as well as the handwritten disciplinary notes signed by Mr Fatola 6 September 2018.

Upon having viewed the CCTV footage, the panel noted that Mr Fatola entered Resident B's room at 21:07 and left his room at 21:12. The panel noted that Mr Fatola carried a silver tray into the room and that there was no trolley present.

The panel further noted that within the disciplinary notes it states:

> "[Colleague B] asked why he has not followed the policy and as seen on CCTV he carried drugs on a tray. Trolley is left in corridor – [Mr Fatola] does not take with him. [Colleague B] asked for explanation.
>
> [Mr Fatola] said he takes it to lift door. He checks charts and does them 1x1. [Colleague B] states that CCTV shows he carries them on a tray. [Colleague B] queried why he goes 1x1 and not take trolley upstairs? He says lift not reliable and stated that he only put them on a tray this once. "

The panel noted that the handwritten disciplinary notes signed by Mr Fatola 6 September 2018 states he said that “lift not reliable.”

The panel further had sight of the Home’s policy and procedure for ordering, storing, administering and disposal of medicines. It states that: “all medication will be dispensed from the medication trolley at all times”. In oral evidence Colleague B informed the panel that the MAR charts were contained in a large folder which was not with the silver tray in the CCTV footage.

In light of the above evidence, the panel found that between 26 August and 27 August 2018, Mr Fatola administered medication without the use of the drug trolley and medication administration record charts.

In these circumstances, the panel found this charge, proved.

Charge 3c

> “Between 26 August and 27 August 2018;
>
> > Being the sole qualified nurse on night duty, slept on one or more occasions during the shift.”

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Colleague A.

The panel noted that Colleague A stated in her witness statement dated 16 March 2019 that:

> “I walked into the nurses’ office and found Sunday sitting on a computer chair with his feet up on another chair and his eyes closed. His breathing was making hissing sounds and from his presentation I believed he was asleep. I approached Sunday, placed my hand under his left shoulder and nudged him once. Whilst doing this I said we needed him to come upstairs to see Resident B because his catheter was bypassing. I did not get a response from Sunday; his eyes remained closed and his breath continued to hiss.”

The panel bore in mind that Colleague A’s oral evidence confirmed the details of her witness statement. The panel accepted Colleague A’s evidence.

The panel further noted that there was another allegation advanced by Mr Rye that Mr Fatola had been asleep from 03:53 to 05:46. The panel noted that this allegation was based purely on CCTV evidence and the panel was of the view that there were gaps and inadequacies within the CCTV footage. Therefore the panel did not have sufficient evidence to deduce that Mr Fatola slept on more than one occasion. However, it was satisfied from the evidence of Colleague A that Mr Fatola, between 26 August and 27 August 2018, slept on one occasion during the shift.

Accordingly, the panel finds this charge proved.

Charge 4

> “On 26 August 2018 at 23:06 failed to respond to a call for assistance from Resident B.”

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and written evidence of Resident B, Colleague B and the photographic evidence of a call log of Resident B’s phone.

It noted that Resident B stated in his witness statement dated 7 February 2019 that:

> "I am unable to remember if I saw Sunday at all at any point during that shift. I am also unable to remember calling the nurses' office from my mobile phone for help. I am unable to recall reporting any concerns I had during this shift to anyone."

The panel also noted Colleague B's witness statement dated 19 March 2019 in which she stated that:

> "I showed Sunday pictures that I had taken of Resident B's phone for the night in question… showing that Resident B called on 26 August 2018 at 23.06 hours and then 27 August 2018 at the following times 03:52 hour, 07:34 hours, 08.23 hours and 08:38 hours.
>
> Sunday insisted that Resident B had not phoned at those times and there must have been a problem with the phones. He said that Resident B had called at around 05.00 hours but I drew his attention to the fact that there was no record of this on Resident B's mobile phone."

The panel had sight of a call log at 23:06 showing a call lasting 31 seconds. It further bore in mind the contents of the CCTV log provided by Colleague B where it was noted that Mr Fatola was seen speaking to an HCA, Colleague E, at 23:18. The panel noted that Resident B's notes had an entry within it at 12:05 by Colleague E that Resident B was checked, he had been awake but settled when she visited him.

The panel was of the view that there was no duty of care on Mr Fatola in particular to answer the call. The panel has evidence before it to demonstrate that a member of staff had attended to Resident B. The panel was of the view that it would have been adequate for an HCA to respond to a telephone call rather than Mr Fatola being required to go to Resident B himself.

The panel reminded itself that the burden of proof at the fact finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and, therefore, on the balance of probabilities, the panel found this charge not proved.

Charge 5

> "On 27 August 2018 at 03:52 and 07:34 failed to respond to calls for assistance from Resident B."

This charge is found NOT proved.

In reaching this decision, the panel took into account the daily notes for Resident B and the photographic evidence of a call log of Resident B's phone. The panel also had before it generalised evidence as to whether calls were always answered or not. This evidence was in Resident B's statement and in the document produced by Colleague C which is marked 'complaint' as a record of what Resident B said to her on the day the shift ended.

The panel noted that there is evidence that a phone call was made at 03:52 to the Home from Resident B's mobile lasting 2 minutes. It also noted that an entry was made in Resident B's daily notes by Colleague D shortly after this at 04:10, recording: "Resident B was checked, he is asleep." The panel further noted that at 04:15 there is an entry on the daily notes was recorded by the 'visiting professional': "Called to Resident B as he rang down. Changed pad as bypassing still. Left settled. Informed nurse again." There appears to have been a response to the call made at 03:52.

The panel noted that there is evidence that a phone call was made at 07:34 to the Home from Resident B's mobile lasting 26 seconds. The panel had no specific evidence before it if any action had been taken in response to this call.

At 07:40 Mr Fatola completed an entry in Resident B's daily notes summarising the shift.

The panel bore in mind that the CCTV footage stops at 06:51 and therefore it was not possible for the panel to get any corroboration from it.

The panel was also of the view that there is no particular duty of care upon Mr Fatola alone to answer these calls which came through to a shared line at the Home.

The panel reminded itself that the burden of proof at the fact finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof by producing a call log alone and, therefore the panel found this charge not proved.

Charge 6

> "On 6 September 2018 during a formal disciplinary meeting, told the registered home manager colleague B that you had checked on Resident B on more than 1 occasion during the night shift of 26 – 27 August 2018."

This charge is found proved.

In reaching this decision, the panel had regard to all the oral and documentary evidence adduced.

The panel was of the view that the handwritten notes of the disciplinary meeting signed by Mr Fatola dated 6 September 2018 provides sufficient evidence to find this charge proved, in that it shows Mr Fatola did say that he did check on Resident B on more than one occasion during the night shift. It is also likely that he said that, because this was also contained in his internal written statement, dated 3 September 2018.

The panel therefore finds this charge proved.

Charge 7

> "Your action in charge 6 above were dishonest in that you knew you had not checked Resident B on more than 1 occasion during the night shift of 26 – 27 August 2018."

This charge is found NOT proved.

In reaching this decision, the panel took into account the CCTV evidence, the written evidence of Resident B and Colleague A.

The panel noted that it had viewed on CCTV evidence that Mr Fatola entered Resident B's room at 21:07 with a medication tray and left the room at 21:12. The panel also took into account Resident B's evidence which was further confirmed by Colleague A's evidence that Mr Fatola had attended to check Resident B's catheter sometime between 22:00 and 23:00.

The panel further noted that there may have been a third occasion in which Mr Fatola checked on Resident B where he had said he checked on Resident B at 01:35. The panel bore in mind that Mr Fatola was challenged on this matter at the internal disciplinary meeting purely on the basis of the alleged CCTV evidence.

This panel has decided that it cannot rely on the CCTV evidence to prove a negative, because it has found a significant omission in the CCTV evidence, particularly that it omits the attendance of Mr Fatola and two HCAs at about 22:30. The panel bore in mind that Mr Fatola had not made a note of the 01.35 visit in Resident B's notes. The panel has commented that this did not represent adequate action to deal with the concern about the catheter at charge 3a, however, it was not satisfied that it has been proved that the visit to Resident B's door was not made.

The panel reminded itself that the burden of proof at the fact finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and, therefore, on the balance of probabilities, the panel found this charge not proved.

Charge 8

> "On 6 September 2018 during a formal disciplinary hearing, told the registered home manager colleague B that Resident B had called you at 05:00 on 27 August 2018."

This charge is found proved.

In reaching this decision, the panel took into account the handwritten notes of the disciplinary meeting signed by Mr Fatola dated 6 September 2018 and Mr Fatola's written internal statement dated 3 September 2018.

The panel noted that within the handwritten notes of the disciplinary meeting Mr Fatola had stated that Resident B only called by telephone at 05:00. The panel also noted that in Mr Fatola's written internal statement, he had stated that the single telephone call was made at 05.30.

It was the panel's view that the precise time might have been uncertain. However, the panel accepted that Mr Fatola said that a telephone call was made at 05:00 and therefore it concluded that the facts set out at charge 8 have been established.

The panel therefore found this charge proved.

Charge 9

"Your actions in charge 8 above were dishonest in that you knew Resident B had not called you at 05:00 on 27 August 2018."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of a phone call made by Resident B at 03.52 which lasted for 2 minutes. The panel also took into account Mr Fatola's statement dated 3 September 2018.

The panel noted that Mr Fatola in his statement dated 3 March 2018 said that he thought the phone call was at 05:30. At the disciplinary meeting dated 5 September 2018 Mr Fatola had stated that the phone call was at 05:00.

The panel bore in mind that Mr Fatola had no access to any of the documents and only had notice of this disciplinary meeting the day before. Furthermore it noted that Mr Fatola had not known the details of the meeting. Given these concerns the panel is of the view that it is understandable that there may have been some confusion caused to Mr Fatola about the timing of the phone call and therefore no dishonesty can be implied from the fact that Mr Fatola said the call was made at 05:00 when it appears there was a call shortly before 04:00 to which he might have been referring.

The panel reminded itself that the burden of proof at the fact finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and, therefore, on the balance of probabilities, the panel found this charge not 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 Fatola'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 Fatola's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* The panel applied *Johnson v Maggs [*2013] EWHC 2140 (Admin) where it was held that misconduct going to the issue of impairment needed to be "a serious departure from acceptable standards".

Mr Rye invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision. Mr Rye directed the panel to specific paragraphs and identified where, in the NMC's view, Mr Fatola's actions amounted to misconduct.

In respect of charge 1 and charge 3b, Mr Rye submitted that leaving medication on a tray unattended in an unlocked room lacks the professionalism required of a nurse. He submitted that medication should never be left unattended due to the risks involved, such as a vulnerable patient taking it, especially within an environment where residents suffer with dementia. He submitted that there is a real risk of harm that could be caused by this.

He further added that leaving the medication trolley alone whilst taking medication to residents is “risk taking behaviour”. In addition, he submitted that the purpose of taking medication to each room together with the MAR chart is to avoid unnecessary mistakes with the administering of medication. He submitted that there were Home policies and protocols in place for safeguarding reasons and that there is a real risk that mistakes could occur if this procedure is not followed.

In relation to charge 2, Mr Rye submitted that administering Apixaban when Mr Fatola was not supposed to, may appear not so serious at first, however he submitted that this action is serious. He submitted that Mr Fatola made a clinical decision which went against the instructions provided for Resident A. He submitted that a medication error is still an error, regardless of whether there was actual harm or not and no harm is alleged in this case. He submitted that Mr Fatola made a decision on his own that could have severely impacted on Resident A. He submitted that Mr Fatola should have explored all other options to avoid any unnecessary risk. He submitted that by following what someone else had done previously, which had also been wrong, he put Resident A at risk.

With regards to charge 3a, Mr Rye submitted that failing to take adequate action in relation to Resident B’s catheter was extremely serious. He submitted that Mr Fatola’s failures could have resulted in serious harm to Resident B. He submitted that there was guidance in place with regards catheters and by ignoring them and failing to continually monitor the situation, Mr Fatola placed Resident B at serious risk of harm. He said that by failing to monitor Resident B, Mr Fatola not only breached a fundamental tenet of the nursing profession but also brought the profession into disrepute. He submitted that members of the public will lose trust in the profession if they are aware that nurses are not acting with a duty of care towards their patients.

In respect of charge 3c, Mr Rye submitted that although Mr Fatola was entitled under the practice in the Home to sleep whilst on a break during the shift, he must still be responsive when being beckoned by a colleague. Mr Rye reminded the panel of Colleague A’s evidence in which she said she had to return to Mr Fatola with another colleague to wake

him, who only then responded to their request. He submitted that sleeping whilst on duty and being unresponsive is very serious. He submitted that being unresponsive is a failure in a nurse's duties and obligations to be immediately available if an emergency arises. He submitted that being the sole nurse on duty, Mr Fatola had an obligation to work in partnership with colleagues to make sure that proper care was provided to vulnerable residents with immediate effect.

Mr Rye submitted that the panel, having found charges 6 and 8 proved, must address the question of whether the information that Mr Fatola provided is misconduct. He submitted that since the panel found that there was no dishonesty proved in charges 7 and 9, charges 6 and 8 in themselves do not amount to misconduct. However, he submitted that this was a matter for the panel to consider using its professional judgement.

In these circumstances, Mr Rye submitted that Mr Fatola's actions fell seriously short of the standards that were expected of him in charges 1, 2 and 3 in its entirety and thus amounted to, not only misconduct but serious misconduct.

Submissions on impairment

Mr Rye moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Rye submitted that Mr Fatola has in the past put patients at an unwarranted risk of harm. He submitted that Mr Fatola has also breached fundamental tenets of the nursing profession and has brought the nursing profession into disrepute.

Mr Rye invited the panel to consider whether Mr Fatola's conduct is capable of remediation, whether it has been remediated, and whether his actions are likely to be repeated in future.

Mr Rye submitted that Mr Fatola's medication errors and failure to follow protocol are matters that could be remediated. He submitted however, that Mr Fatola has not engaged with the process or sought to remedy these failings.

Furthermore, he submitted that there is no evidence of insight or remorse from Mr Fatola. He drew the panel's attention to two testimonials and training certificates and submitted that this material is now relatively old and most of the training certificates pre-date the concerns in this case. He submitted that it is a matter for the panel what weight it may attach to them. On this basis, Mr Rye submitted that the concerns in relation to Mr Fatola will likely be repeated.

Mr Rye drew the panel's attention to a previous regulatory sanction imposed on Mr Fatola's practice by the NMC. He submitted that although in that instance it was decided a year later at the end of the 12 months suspension that Mr Fatola's fitness to practise was no longer impaired, this previous concern is relevant to the issue of repetition because Mr Fatola has been through the process once before and is now in a similar position before the NMC with further concerns about his practice. He invited the panel to consider whether there is a real risk that the misconduct could be repeated and submitted that this risk is in fact tangible.

Mr Rye invited the panel to find that Mr Fatola's fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest. He submitted that the panel should consider what a fully informed member of the public would think, should a finding of no current impairment be made in this case.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000]

1 A.C. 311, *Johnson v Maggs [*2013] EWHC 2140 (Admin), *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2007] 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 Fatola's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Fatola's actions amounted to a breach of the Code. Specifically:

"18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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 professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times*"*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, in these circumstances, the panel decided that Mr Fatola's actions in charge 1, 3a and 3b fell so significantly short of the standards expected as to justify a finding of misconduct.

The panel noted that both charges 1 and 3b related to medicines management. It considered that each of the charges taken separately amounted to misconduct. The panel bore in mind that the medicines Mr Fatola left unattended on a tray within an unlocked clinic room on 1 July 2017 and 31 July 2017 included controlled drugs. It further bore in mind that some of the residents at the Home suffer from dementia and that leaving such medication unattended risks the residents' safety. The panel was further of the view that taking medication to a resident without access to the drug trolley and MAR charts in itself increased the risk of a medication errors occurring. It was of the view that Mr Fatola administering medication without both a drug trolley and MAR chart put residents at the Home at risk of medication errors. The panel also bore in mind that doing so was also a clear breach of the Home's internal policy. The panel found each of the charges 1 and 3b to be sufficiently serious to amount to misconduct.

In relation to charge 2, the panel was of the view that this charge could possibly amount to misconduct because Mr Fatola administered Apixaban to Resident A when his prescription for this medication had been placed on hold for 48 hours. However, Mr Fatola was able to articulate his reasons for the administration on the grounds that Resident A had already received a dose of this medication within the 48 hour window from another colleague and therefore could not have had surgery on the due date anyway and a greater harm could have been caused by the omission of the medication. The panel was of the view that it would have been preferable and good practice if Mr Fatola had discussed this with a colleague or had documented his decision making process in the Resident's record. The panel however noted that the wording of the facts at charge 2, is not to this effect. The panel therefore concluded that Mr Fatola's actions at charge 2 were not sufficiently serious to amount to misconduct.

The panel next considered charge 3a. It noted that the failure to take adequate action to deal with the concern raised by Colleague A regarding Resident B's catheter was a serious breach. The panel took account of the underlying medical conditions of Resident B and his particular susceptibility to the implications of a blocked catheter. The panel further bore in mind that the risks of such a concern were specifically highlighted within Resident B's records. The panel further noted that this information was also posted on the walls of the Home's office. The panel was of the view that Mr Fatola should have had particular regard to this matter and that he should have checked on Resident B regularly. The panel further noted that any checks undertaken by Mr Fatola were not recorded. The panel was of the view that such omissions from the Resident's records not only caused a risk of harm to Resident B within his shift but also compromised the next colleague's shift. It noted that Mr Fatola's failure could have had serious consequences for Resident B. The panel found charge 3a to be sufficiently serious to amount to misconduct.

In relation to charge 3c, the panel was the of the view that whilst sleeping at all on duty could be considered misconduct, it bore in mind the evidence at the facts stage and was alert to the fact that doing so was considered to be common practice and it was condoned

by the management of the Home. Whilst it has been established that Mr Fatola was asleep on one occasion it was also noted to be acceptable practice that the nurse on duty 'may sleep lightly during their one hour break'. The panel noted that there was no evidence to suggest that Mr Fatola was not on a break and when he was subsequently roused, he did attend to Resident B at about 22:30. The panel therefore concluded that Mr Fatola's action at charge 3c was not sufficiently serious to amount to misconduct.

The panel bore in mind that in relation to charge 6 and 8, the NMC accepts that they are stand-alone charges and do not allege or amount to misconduct. The panel concurred with this view and therefore did not find misconduct in respect of charges 6 and 8.

The panel therefore concluded that Mr Fatola's actions at charges 1, 3a and 3b did fall seriously short of the conduct and standard expected of a registered 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 Fatola's fitness to practise is currently impaired.

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only*

whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) *…'*

The panel found that the first three limbs of the *Shipman* "test" are engaged. The panel finds that residents were put at risk as a result of Mr Fatola's misconduct. Mr Fatola's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The case of *Cohen* identified that there is a necessity for the panel considering impairment to determine whether the misconduct is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

The panel noted that it was not in possession of any evidence from Mr Fatola regarding his insight. It noted that Mr Fatola had only engaged with the NMC in a limited capacity and had not provided any documentary evidence such as a reflective piece to show any level of insight or remorse. The panel therefore had no information as to whether Mr Fatola has an understanding as to how his actions put the residents at a risk of harm, why what he did was wrong and how this impacted negatively on the reputation of the nursing profession.

The panel was satisfied that the misconduct in this case is capable of remediation. However, it had no information as to whether or not Mr Fatola has remedied his practice. The panel took into account the two testimonials and training certificates provided to it, however it concluded that the certificates provided pre-dated the incidents and had no relevance to the concerns raised in this case. Similarly, the testimonials, whilst positive, did not speak directly to the specific areas of concern identified in this case and were over two years old.

As a consequence of a lack of any evidence of insight, remorse or remediation the panel is of the view that there is a risk of repetition. There is also evidence of repetition from the fact that there are similarities between this case and the case found proved against Mr Fatola by the NMC in 2013. The panel concluded that although there was no actual harm caused to any of the residents, there was potential for harm in relation to medicines storage and administration and his failure to adequately take action in respect of Resident B's catheter. It further bore in mind that Mr Fatola put residents at potential harm by not following the Home's medication management policy. In the absence of any evidence to the contrary, the panel determined that there remained a risk of repetition in this case.

In light of the above, the panel had no evidence before it to allay its concerns that Mr Fatola may currently pose a risk to patient safety. It considered there to be a real risk of repetition of the incidents found proved and it determined that there remains an unwarranted risk of harm to patients in his care, should he be permitted to practise as a registered nurse without restriction. Therefore, the panel 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, in this case, a finding of impairment on public interest grounds was also required. It was of the view that a member of the public would expect a finding of impairment based on Mr Fatola's actions and lack of remediation.

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

Sanction

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

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Rye took the panel through aggravating and mitigating factors which, in the NMC's view, were present in this case.

Mr Rye invited the panel to take into account the risks in this case considering the lack of insight, reflection and remediation. He further reminded the panel to bear in mind the previous regulatory concern. He submitted that the previous concern related to similar concerns as set out in charge 3a, failing to carry out proper assessment of a resident. He submitted that this therefore suggests that the previous order had no real effect on addressing the failings in Mr Fatola's practice. Mr Rye told the panel Mr Fatola has been on an Interim Suspension Order (ISO) since 27 September 2018. He submitted that this might be thought to be relevant to the issue of proportionality with regards any sanction the panel may wish to impose today but he reminded the panel that the ISO was imposed for different reasons in response to a risk assessment and that this panel has found current impairment and the need for public protection.

Mr Rye submitted that due to the nature of this case there is a continuing risk to patient safety and therefore taking no further action would be inappropriate. He submitted that imposing a caution order would be inappropriate for the same reasons. Furthermore, he submitted that a conditions of practice order would not be a sufficient sanction given the non-engagement and the evidence that Mr Fatola does not presently intend to continue with his nursing career. He therefore submitted that no workable conditions could be formulated.

Mr Rye submitted that a suspension order could be the appropriate sanction to impose in this case. He submitted that it marks the seriousness of the failings and protects the public from the risk of harm. He further submitted that a suspension order would also take into consideration the aggravating and mitigating features of this case, including the fact that the previous sanction did not seem to have any effect on Mr Fatola's practice. Mr Rye

submitted that if a suspension order was considered appropriate then it should be for a period closer to 12 months.

He submitted that the option for a strike off is available for the panel if the panel is of the view that Mr Fatola's continued practice is fundamentally incompatible with being a registered professional. He referred the panel to the NMC guidance contained in SAN-1.

Mr Rye submitted that it is a matter for the panel as to what sanction is appropriate and proportionate in the particular circumstances of this case.

The panel was also drawn to Mr Fatola's comments in a telephone note dated 6 October 2020 in which he states:

> "SF confirmed receipt of NMC correspondence but this as well as other NMC correspondence was not opened but placed on a pile… there is nothing further to add."

Decision and reasons on sanction

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

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

The panel took into account the following aggravating features:

- Mr Fatola was the sole nurse in charge;

- There were vulnerable residents within his care and Resident B especially needed care and monitoring;
- Mr Fatola displayed attitudinal concerns by ignoring policies surrounding medication and guidance regarding risks with catheters and ignoring a vulnerable resident's identified care and monitoring needs;
- There is a previous regulatory concern regarding similar misconduct;
- Mr Fatola has not provided any evidence of insight, reflection or remediation; and
- Lack of engagement with the process.

The panel also took into account the following mitigating features:

- Two testimonials provided that attest to Mr Fatola's general competence as a nurse.

The panel considered that the aggravating factors greatly outweighed the mitigating factor and rendered this case more serious than might initially have been apparent.

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 and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel was of the view that Mr Fatola's misconduct was not at the lower end of the spectrum of fitness to practise and that a caution order would be inappropriate in view of the seriousness of the case and would not provide any protection for the public. 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 a conditions of practice order on Mr Fatola's nursing registration would be a sufficient and appropriate response. It noted that the concerns identified in this case are remediable. However, it bore in mind that Mr Fatola has disengaged with the NMC process. The panel was of the view that conditions of practice are only appropriate when the panel can be confident that the registrant is willing to engage with such conditions. This panel has evidence before it to suggest that Mr Fatola has no willingness to engage with such an order.

In taking account of the above, the panel determined that placing a conditions of practice order on Mr Fatola's nursing registration would not adequately address the seriousness of this case, nor would it satisfy the public protection or public interest considerations.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel noted that Mr Fatola's conduct was not a single incident. It further noted that there was a previous relevant fitness to practice finding against Mr Fatola by the NMC. It took account of the NMC's guidance marked SAN 1- "Factors to consider before deciding on sanction- previous fitness to practice history" where it is stated:

> "The nurse or midwife's fitness to practice history with us can be relevant to a decision on sanction. It's most likely to be useful in cases about similar kinds of concerns. If problems seem to be repeating themselves, this may mean that previous orders were not effective to help the nurse or midwife address them. If the panel is considering in making a similar order to those made by previous panels, it may need to take this factor into account and reconsider if necessary."

The panel noted Mr Fatola's misconduct in the past and considered that there were clear similarities between this case and the one for which he was suspended in 2013. Although he satisfied the review panel in 2014 that his practise was no

longer impaired, the events in this case arose only three or four years later. The particular similarity the panel noted was that although Mr Fatola was alerted to a significant problem with a vulnerable resident, he did not provide that resident with due care. The panel noted that in this case, Mr Fatola failed to monitor a situation where the resident had specific and identified medical condition that made him vulnerable to very serious consequences from a blocked catheter. The panel noted that Mr Fatola had not provided or even attempted to provide the panel with any evidence of insight, remorse or remediation, and further had told the NMC that he had left communication about this hearing from the NMC 'unopened on a pile' at his home. The panel was therefore of the view that his behaviour was indicative of an attitudinal issue. It further noted that Mr Fatola's lack of patient care and reckless attitude to patient risks to which he had been alerted goes against the fundamental public expectation and requirements for a registered nurse. This uncaring attitude has been exacerbated by failures to follow the Home policies both in 2017 and 2018.

The panel noted that Mr Fatola has offered no evidence by way of insight into his misconduct; despite having a substantial amount of time to reflect on his behaviour. The panel noted that Mr Fatola has not worked in a clinical environment since being suspended from the Home in September 2018. He has been subject to an ISO from the NMC since September 2018 but he could have taken steps to show to this panel that he had understood the consequences of his actions and that he would not act in a similar way again in future.

Taking account of the above, the panel determined that Mr Fatola's actions were not merely serious departures from the standards expected of a registered nurse and serious breaches of the fundamental tenets of the nursing profession, they were fundamentally incompatible with him remaining on the NMC register. In the panel's judgment, to allow someone who had behaved in this way to maintain his NMC registration would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

In reaching its decision, the panel bore in mind that its decision would have an adverse effect on Mr Fatola both professionally and personally. However, the panel was satisfied that the need to protect the public and address the public interest elements of this case outweighs the impact on Mr Fatola in this regard.

Balancing all of these factors and after taking into account all the evidence before it adduced in this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Fatola's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. Therefore, the panel decided to impose a striking off order.

Interim order

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

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

Submissions on interim order

The panel has considered the submissions made by Mr Rye that an interim suspension order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and it is in the public interest.

Decision and reasons on interim order

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

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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. Owing to the seriousness of the misconduct in this case and the risk of repetition identified, it determined that Mr Fatola's actions were sufficiently serious to justify the imposition of an interim suspension order until the striking-off order takes effect. In the panel's judgment, public confidence in the regulatory process would be damaged if Mr Fatola would be permitted to practise as a registered nurse prior to the substantive order coming into effect.

The panel decided to impose an interim suspension order in the circumstances of this case. To conclude otherwise would be incompatible with its earlier findings.

The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.