Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
24 – 27 May 2021
1 – 2 July 2021

Virtual Hearing

Name of registrant:	Adeniyi Adisa Adesanya
NMC PIN:	05D0488E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – October 2005
Area of registered address:	London
Type of case:	Misconduct
Panel members:	Nigel Hallam (Chair, lay member) Anne Grauberg (Registrant member) Tricia Breslin (Lay member)
Legal Assessor:	Michael Levy
Panel Secretary:	Ruth Bass (24-26 May 2021) Amira Ahmed (27 May 2021) Catherine Acevedo (1–2 July 2021
Nursing and Midwifery Council:	Represented by Case Presenter, Alfred Underwood (24-27 May 2021) Yusuf Segovia (1-2 July 2021)
Mr Adesanya:	Present and unrepresented (24-27 May 2021) Not present and unrepresented (1-2 July 2021)
Facts proved:	1, 2, 3, 4 and 5
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order

Details of charge

That you, a registered nurse:

1. *On 17th November 2018, performed CPR on Resident A in breach of the DNAR arrangement that was in place;*

2. *Having performed CPR on Resident A, failed to record this information on Resident A's care plan;*

3. *Your action at Charge 2 was dishonest as you knew you had performed CPR on Resident A and you were seeking to conceal your error.*

4. *On 17 November 2018 when Colleague 1 arrived at the Home, you inaccurately said you had not performed CPR on Resident A, or words to that effect;*

5. *Your action at Charge 4 above was dishonest in that you were seeking to conceal your actions at Charge 1 from Colleague 1*

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

Decision and reasons on application of no case to answer

In light of you being unrepresented, the legal assessor asked the panel to consider whether there was a case to answer in respect of all of the charges under Rule 24(7), which states:

*'**24.**— (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –*

(i) either upon the application of the registrant, or

(ii) of its own volition,

the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.'

In relation to this application, Mr Underwood submitted that there was overwhelming evidence that a DNAR arrangement was in place, and evidence had been provided by two witnesses that CPR was conducted by you. He further submitted that there was sufficient evidence, not of a tenuous nature in respect of each charge and set out the evidence adduced in respect of each charge. In these circumstances, it was submitted that all the charges should remain before the panel.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Facts

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

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 under affirmation from the following witnesses called on behalf of the NMC:

- Colleague 1: Home Manager at the time of the incident
- Colleague 2: Team Leader at the Home at the time of the incident
- Colleague 3: General Nurse at the Home at the time of the incident
- Ms 4 Information Governance Officer at the South Central Ambulance Service NHS Trust
- The panel also heard evidence from you under affirmation.

The panel also considered a number of statements and documents including those from Colleague 5 included in the NMC bundle of evidence.

Background

The charges arose whilst you were employed as a registered nurse at Woodland Manor Nursing Home ("the Home"). You began your employment at the Home on 30 August 2017.

The Home contains 64 beds over 2 floors and you would usually work the night shift on floor 1. Among other residents at the home, you had taken care of Resident A when she had been a resident on floor 1.

Resident A had a Do Not Resuscitate arrangement, or "DNAR" in place. This directed in the event of cardiac or respiratory arrest no attempts at CPR should be made for this person.

You told the panel you were the only registered nurse working a night shift on 16 to 17 November 2018 on floor 1.

Resident A was very unwell. She had been seen by her General Practitioner (GP) the day before who diagnosed a chest infection and had also prescribed end of life medications. Her breathing had become laboured and you had contacted the out of hours GP to review her. The emergency buzzer went off in Resident A's room. Resident A had stopped breathing.

It is accepted that you had known Resident A for around a year and ought to have been aware that a DNAR arrangement was in place. Resident A had a cardiac arrest and it is alleged you performed CPR in direct contravention of the DNAR document.

It is further alleged that having performed CPR, you failed to update the care plan for Resident A to state that this resuscitation had been attempted.

It is further alleged that you were dishonest in failing to update the care plan, as you were seeking to conceal the fact that CPR had been conducted in contravention of the DNAR document.

It is also alleged that when asked in person by Colleague 1, your Manager at the time, if you had performed CPR, you said that you had not, although that was not the impression you had given her previously during a telephone call. It is alleged that this was dishonest in that you were deliberately attempting to mislead Colleague 1.

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 both the NMC and by you.

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

Colleague 1: The panel considered the evidence of Colleague 1 to be credible. Although it found her oral evidence to be unclear at times, the panel was of the view that Colleague 1 was very clear and consistent that, upon arriving at the Home in the early hours of the morning, you told her that you had not carried out CPR to Resident A. The panel was of the view that Colleague 1 had followed due process with regard to the investigation of the incident and had sought to establish whether CPR had been carried out on Resident A.

The panel noted that Colleague 1 in her oral evidence stated that there had been 2 telephone calls between you. The first call was made by yourself to Colleague 1 and the second call was made by Colleague 1 to you. It was of the view that although this was not initially clear from her witness statement dated 7 October 2019, her statement did allude to the fact there were 2 telephone calls and that this was not a change to her original statement. Paragraph 14 of Colleague 1's statements states:

'When I got to the Home I spoke to Ade he said he did not perform CPR, I had understood from my phone call to him that he had'

Colleague 2 – The panel found Colleague 2's written evidence to be very clear. It had regard to the fact that Colleague 2's initial statement dated 21 November 2018 was written shortly after the incident and considered this to be a contemporaneous account. The panel noted that although Colleague 2 had stated in this written account that you had commenced CPR, during his oral evidence he stated he could not remember whether you had carried out CPR. The panel was of the view that there was no reason to believe that the contemporaneous account would be inaccurate. The panel found Colleague 2 to be an honest and cautious witness who sought to be sure of the evidence he gave in light of the potential consequences for you.

Colleague 3 – The panel found Colleague 3 to be a credible witness with a good recollection of the processes in place at the Home at the time of the incident and the physical state of Resident A. The panel was of the view that Colleague 3 had provided good contextual background to the charges concerning Resident A's deteriorating health, the processes at the Home regarding the electronic filing system, where the DNAR information could be found and the handover given to you. The panel had regard to the fact that she was not present at the time of the allegations, and that her evidence concerning the charges amounted to hearsay evidence.

Ms 4 - The panel found Ms 4 to be an honest witness. Ms 4 was not the person who took the emergency phone call and was only able to assist the panel by confirming how the transcript was produced.

Mr Adesanya: The panel noted your long and unblemished career as a registered nurse. However, the panel found your evidence to be unclear and confusing. It noted that your oral evidence was in contradiction with the other witnesses. In particular it noted that your evidence was in contradiction with the independent paramedic report

and the transcript produced by the South Central Ambulance Service NHS Trust, in which you stated *'We're just giving her chest compressions anyway'.* When questioned by the panel about your comments in the transcript you stated that you told the call operator that you had started compressions, but asserted to the panel that you had not done this. Furthermore you told the panel that you were not aware that Resident A had a DNAR document. The panel was of the view that if you genuinely believed that Resident A did not have a DNAR arrangement in place you should have been carrying out chest compressions. The panel was of the view that your evidence lacked credibility and was at times contradictory. You believed you had been *"stitched up"* by the Home, however the transcript of the emergency 999 call was independent evidence and you were unable to satisfactorily explain why you informed the operator that CPR had already been started.

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

Charge 1

'That you, a registered nurse:

1. On 17th November 2018, performed CPR on Resident A in breach of the DNAR arrangement that was in place;'

This charge is found proved.

In reaching this decision, the panel first considered whether a DNAR arrangement was in place. The panel had regard to the DNAR arrangement dated 4 June 2017. It noted that the agreement had been in place for over 1 year 5 months and that Resident A had been under your care on your floor prior to being moved to the ground floor. The panel also had regard to the fact that there was a note on the first page of Residents A's electronic care plan that a DNAR was in place and that the DNAR arrangement had

been scanned into Resident A's electronic records. The panel also heard evidence from Colleague 1 and Colleague 3 that the status for residents having DNAR arrangements was recorded on a white board in each medication room. The colour coding gave the name of the residents in red who had a DNAR in place, and those residents names who did not have a DNAR in place were written in green. The panel accepted the evidence of Colleague 3 that she reminded you at the handover shift on the night in question that Resident A had a DNAR in place. The panel also had regard to the fact that a paper copy of the DNAR arrangement was eventually provided to the paramedics as recorded by Colleague 2. Having considered all of this evidence, the panel was satisfied that a DNAR arrangement for Resident A was in place.

The panel considered whether you knew, or ought to have known, whether there was a DNAR arrangement in place for Resident A. The panel had regard to your evidence that you contacted Colleague 1 by phone to ask where the DNAR arrangement for Resident A was. The panel was of the view that if you did not know there was a DNAR arrangement for Resident A, you would not have been looking for one and there would have been no reason for you to contact Colleague 1. The panel also had regard to the fact that you are a registered nurse who had been caring for Resident A for some time prior to the incident and ought to have known from updating her care plan and accessing her files that a DNAR arrangement was in place. The panel also considered the evidence of Colleague 3 who gave evidence that Resident A frequently spoke about the fact that she did not want to be resuscitated. Based on this evidence the panel was satisfied that you did know that a DNAR arrangement was in place for Resident A.

The panel next went on consider whether you did perform CPR. It had regard to the contemporaneous accounts of Colleague 2, Colleague 5, South Central Ambulance Service NHS Trust Transcript and the Paramedic Report. The Paramedic Patient Clinical Report dated 17 November 2018 stated *"CPR in progress for 5 minutes before crew arrival."*

Colleague 2's statement dated 21 November 2018 stated:

We put altogether the service user on the floor and RGN Ade started chest compression (sic)'.

Colleague 5's statement dated 20 November 2018 also stated: "Ade said please help me to put Resident A on the floor. He started to do the chest compressions for 2 minutes."

The panel also considered the transcript from the 999 call and noted the multiple times that you confirmed that CPR had been started:

'OPERATOR: Okay. Are they doing CPR now?
CALLER: Yes.
OPERATOR: They're already doing it?
CALLER: Yes.
OPERATOR: Okay. Have you got a defib?
CALLER: No, we don't have.
OPERATOR: You don't have a defibrillator. Okay, that's fine.
CALLER: No, no.
OPERATOR: So you say they're already doing it at the moment, yeah?
CALLER: Yes. Yes.
OPERATOR: Okay. Thank you.
CALLER: We're just giving her chest compressions anyway. That's ---
OPERATOR: They're giving chest compressions. Yeah, that's absolutely fine. And she's on the floor, is she?
CALLER: Yes.
OPERATOR: Yeah, okay. And she's flat on her back?
CALLER: Yes.

Having noted that you confirmed to the 999 operator that CPR had already commenced, having accepted the contemporaneous evidence of Colleague 2 and Colleague 5, the panel was satisfied that CPR had been commenced by you.

Having considered all of the above, the panel found on the balance of probabilities that you did perform CPR on Resident A in breach of the DNAR arrangement. It therefore finds charge 1 proved.

Charge 2

That you, a registered nurse:

> Having performed CPR on Resident A, failed to record this information on Resident A's care plan;

This charge is found proved.

In reaching this decision, the panel had regard to its finding in charge 1 that you did perform CPR on Resident A. It then had regard to your comments contained in Resident A's care notes for 17 November 2018 and noted that there was no record made of you having carried out CPR on Resident A. It was clear from the records that you had written the notes pertaining to Resident's A's care on the night in question and that there was no mention of CPR having been commenced by you or at all. The panel therefore found charge 2 proved.

Charge 3

That you, a registered nurse:

> Your action at Charge 2 was dishonest as you knew you had performed CPR on Resident A and you were seeking to conceal your error.

This charge is found proved.

The panel had regard to your oral evidence that you had placed Resident A on the floor but did not commence any chest compressions. You were consistent throughout your oral evidence that you did not commence CPR on Resident A. However, following the panel's finding in charge 1 that you did commence CPR on Resident A, and the fact that you did not record this in the care plan, the panel found that your omission in recording that you had commenced CPR was a dishonest attempt to conceal your error. It had regard to the fact that you documented that the paramedics '*could have started chest compressions'* against Resident A's wishes, and intended to make a safeguarding referral. The Paramedic Report stated *'CPR in progress before crew arrival, CPR continued until DNACPR produced.'*

The panel also had regard to the fact that there was no mention in the care records made by you that you had moved Resident A from her bed to the floor, which it believed should have been recorded had there been a real attempt by you to be transparent. The panel was satisfied that ordinary persons would find your omission to record CPR in the Resident A's care notes was dishonest. It therefore found charge 3 proved.

Charge 4

That you, a registered nurse:

> On 17 November 2018 when Colleague 1 arrived at the Home, you inaccurately said you had not performed CPR on Resident A, or words to that effect;

This charge is found proved

In considering this charge the panel had regard to Colleague 1's statement dated 7 October 2017 which states:

'When I got to the Home I spoke to Ade and asked him about the incident. He said he did not perform CPR, I had understood from my phone call to him that he had.'

The panel considered the way in which Colleague 1 had reacted to your communications with her concerning the incident. The panel had regard to Colleague 1's oral evidence where she asserted that when she rang you back you told her that you had done CPR therefore when she arrived at the Home and was told by you then that you had not commenced CPR, she was relieved at this.

You told the panel that you had contacted Colleague 1 by phone to find out where the DNAR arrangement for Resident A was. Colleague 1 said that she called you back later and you had not found the DNAR form. Colleague 1 then made the decision to come into the Home as she was concerned and unsure as to whether CPR had been carried on Resident A. The panel was of the view that Colleague 1's actions in coming to the Home in the early hours of the morning following her concern that CPR may have been commenced in light of the DNAR being found, and feeling genuine relief to be told you had not commenced CPR was indicative of the fact that you had expressed that you had not commenced CPR. The panel accepted Colleague 1's evidence that you had informed her that you did not commence CPR and therefore found charge 4 proved.

Charge 5

Your action at Charge 4 above was dishonest in that you were seeking to conceal your actions at Charge 1 from Colleague 1

This charge is found proved

The panel had regard to your statement dated 17 November 2018 and noted that you did not include the fact that you had started doing CPR in your account. It was of the

view that this was an attempt to conceal your actions from Colleague 1 and mislead her as to what had happened. It further had regard to the 999 call transcript in which you stated that CPR had commenced, but again failed to include this in your statement for the Home. The panel was satisfied that ordinary people would find you had inaccurately said you had not performed CPR on Resident A was dishonest. It therefore found charge 5 proved.

Application to adjourn

The panel heard submissions from Mr Underwood on misconduct and impairment. You submitted that you have read the panel's decision on the facts and now understand the seriousness of this case. You submitted that you have a 16 year nursing career that you believe to now be in jeopardy and would like sufficient time to make enquiries about representation. You explained that you had membership of GMB Union and are going to be contacting another union for advice and potential representation.

Mr Underwood submitted that he was not against the idea of an adjournment but that you should've been aware of the seriousness of this case by now. He submitted that any adjournment that is made should be short and is a matter for the panel.

The panel accepted the advice of the legal assessor who referred the panel to Rule 32 which sets out a number of factors which panels should consider when deciding an application for an adjournment. In particular fairness to the parties in being able to properly and sufficiently present their cases.

The panel was of the view that given the nature of the case and the seriousness of the allegations, it would be unfair to you to proceed without giving you the opportunity to obtain representation. Taking into account fairness to both parties, and the public interest in the expeditious disposal of this case, as well as the interests of justice, the panel determined to allow the application to adjourn the hearing for a short period. The panel determined that the adjournment period will allow you the time to provide

documentation such as references, testimonials and a reflective statement which you have not done so until now and to also seek legal representation.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of the resumed hearing that Mr Adesanya was not in attendance and that the Notice of Hearing letter had been sent to Mr Adesanya's registered email address on 10 June 2021.

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

Mr Segovia, 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 Adesanya 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 Adesanya

The panel next considered whether it should proceed in the absence of Mr Adesanya. It had regard to Rule 21 and heard the submissions of Mr Segovia who invited the panel to continue in the absence of Mr Adesanya.

Mr Segovia submitted that the hearing was adjourned to allow Mr Adesanya to obtain representation for the hearing and to give him an opportunity to provide testimonials, references and a reflective statement which he has not submitted.

Mr Segovia submitted that the only recent contact from Mr Adesanya to the NMC was in an email dated 30 June where he indicated that he had not managed to obtain representation for the hearing and that he would like to continue with the case as originally planned. The panel afforded Mr Adesanya additional time to contact the NMC during two recesses where the panel secretary attempted to contact him by email, two mobile phones and his landline and left a voicemail for him. However, there was no contact made by Mr Adesanya to the NMC after these recesses had expired. There had been no other engagement at all by Mr Adesanya with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that a further adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* 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 Adesanya. In reaching this decision, the panel has considered the submissions of Mr Segovia, 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 a further adjournment has been made by Mr Adesanya;
- Mr Adesanya has not meaningfully engaged with the NMC;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- There is a strong public interest in the expeditious disposal of the case.

The panel noted there may be some disadvantage to Mr Adesanya in proceeding in his absence. However, such disadvantage is the consequence of Mr Adesanya'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.

However, the overriding view of the panel was that it is fair, appropriate and proportionate to proceed in the absence of Mr Adesanya.

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 Adesanya'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 Mr Adesanya's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

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.'*

Mr Segovia endorsed the submissions made before the hearing adjourned on 27 May 2021 by Mr Underwood. Mr Underwood invited the panel to take the view that the facts found proved amounted to misconduct. He identified the specific, relevant standards of the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code), where Mr Adesanya's actions amounted to misconduct. He submitted that administering CPR when a DNAR was in place and the patient was clear they wished to pass away peacefully, would have profoundly impacted on the resident

psychologically. This conduct, the panel may consider breached the Code in respect of listening to people and responding to their preferences and concerns which is covered under Section 2 of the Code. In respect of the dishonesty, this clearly breached the Code specifically at point 20.2. It was submitted that the dishonesty was a deliberate attempt to cover up a mistake. It is the NMC's position that the facts found proved amount to misconduct.

Mr Segovia 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).

It was submitted on behalf of the NMC that Mr Adesanya's actions risked causing emotional and psychological harm to Resident A. Mr Adesanya's dishonesty was serious and he has demonstrated a lack of insight.

In relation to insight, it was submitted that Mr Adesanya demonstrated a cavalier attitude towards training and the processes within the home. Mr Adesanya said that he did not go to the training on the new systems because it was during the day, and he worked night shifts. Mr Adesanya also stated that he did not attend the disciplinary hearing at his employer because he thought they had pre-judged the outcome but also because it was at 3 o'clock in the afternoon and he worked night shifts. It was submitted that Mr Adesanya seemed unable to comprehend why his employer took this matter so seriously and why they felt it necessary to commence a disciplinary procedure and refer him to the NMC. This demonstrates a lack of insight into this incident and how it reflects not only on his own practise but the nursing profession as a whole.

Mr Segovia submitted that, Mr Adesanya had not provided any information to the NMC between the hearing being adjourned in May 2021 and today's date. Given that there is no new information regarding Mr Adesanya's insight or remediation, it is submitted that Mr Adesanya's fitness to practice remains impaired.

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

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 Adesanya's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Adesayna's actions amounted to a breach of the Code. Specifically:

> *"**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*
>
> *1.3 avoid making assumptions and recognise diversity and individual choice*
>
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> *1.5 respect and uphold people's human rights*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share in decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

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

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

20.5 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, midwives and nursing associates to aspire to

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register. To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel found that Mr Adesanya's actions breached the Code in many ways as outlined above. In respect of the dishonesty, the panel was of the view that this breached the Code in relation to Mr Adesanya's professional duty of candour and was a deliberate attempt to cover up his mistake.

The panel found that Mr Adesanya's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

a)

b) 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.

c)

d) 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:*
>
> *e) 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*

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

g) 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

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

The panel found limbs a-d to be engaged in the *Grant* test as a result of Mr Adesanya's misconduct. His misconduct and dishonesty breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to such significant breaches of the fundamental tenets of the nursing profession to be extremely serious.

Regarding insight, the panel considered that throughout the hearing, Mr Adesanya had demonstrated a lack of insight and understanding into the impact his actions had on the patient and her relatives, his colleagues and the wider nursing profession. The panel noted that despite the adjournment, there had been no new information or reflective statement provided that may have demonstrated that his insight had developed or how he might act differently in the same situation.

The panel was satisfied that the misconduct in this case is capable of remediation. The panel carefully considered the evidence before it in determining whether or not Mr Adesanya has remedied his practice. The panel took into account that it had received

no evidence of training Mr Adesanya has undertaken or references or testimonials attesting to his good practice or character. The panel is of the view that there is a high risk of repetition based on the absence of any evidence of insight, remediation or remorse. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required.

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

Having regard to all of the above, the panel was satisfied that Mr Adesanya'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 Adesanya off the register. The effect of this order is that the NMC register will show that Mr Adesanya 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 Segovia informed the panel that in the Notice of Hearing, the NMC had advised Mr Adesanya that it would seek the imposition of a suspension order for a period of 12 months with a review if it found his fitness to practise currently impaired. Mr Segovia outlined to the panel what the NMC should consider as the aggravating and mitigating factors of this case.

Decision and reasons on sanction

Having found Mr Adesanya'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 Adesanya's dishonesty occurred in a clinical setting and continued throughout these proceedings.
- Mr Adesanya's dishonesty breached the duty of candour.
- Mr Adesanya has demonstrated a lack of insight into his failings.
- Mr Adesanya has provided no evidence of remediation.
- Mr Adesanya has not engaged with the resumed proceedings.
- Mr Adesanya has shown no remorse.

The panel also took into account the following mitigating features:

- Mr Adesanya's misconduct arose from a single incident.

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 not protect the public nor would it be in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Adesanya's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Adesanya's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Adesanya's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the lack of engagement from Mr Adesanya. The misconduct identified in this case in relation to dishonesty was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Adesanya's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

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

The panel noted that Mr Adesanya had hitherto an unblemished nursing career of over 15 years. The panel was of the view however, that although Mr Adesanya's misconduct arose from a single incident, he has maintained his dishonesty throughout the proceedings, shown no remorse and has not demonstrated any insight into his conduct. Considering all of the above, the panel viewed this to be evidence of a harmful deep-seated personality or attitudinal problem. The panel also considered that although the misconduct has not been repeated, Mr Adesanya's deception has been longstanding. The panel was of the view that in the absence of any insight there was a significant risk of Mr Adesanya repeating his behaviour.

The panel also noted that Mr Adesanya's request for an adjournment of the hearing in May 2021 afforded him the time to provide evidence of insight and remediation. This he has failed to do and, in the panel's view, this further demonstrates Mr Adesanya's attitudinal problems and his lack of insight into the seriousness of his behaviour.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Adesanya's actions and absence of any insight, remediation or remorse is fundamentally incompatible with him remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

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

Mr Adesanya's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Adesanya's actions were serious, there is a risk of repetition and therefore to allow him to continue practising would not protect the public and would also undermine public confidence in the profession and in the NMC as a regulatory body.

In making this decision, the panel carefully considered the submissions of Mr Segovia in relation to the sanction that the NMC was seeking in this case. The SG states *"The most serious kind of dishonesty is when a nurse midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong".* The panel decided, in light of the seriousness of the dishonesty and the breach of Mr Adesanya's professional duty of candour, to reject the NMC's sanction bid.

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. Having regard to the effect of Mr Adesanya'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 protect the public, 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.

This decision will be confirmed to Mr Adesanya in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel 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 Adesanya's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.