Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 31 July – Monday 7 August 2023
Thursday 24 – Friday 25 August 2023

Virtual Hearing

Name of Registrant:	**Adeniyi Julius Odukunle**
NMC PIN	20G2789E
Part(s) of the register:	Registered Nurse – RNA Adult Nursing – August 2020
Relevant Location:	Gloucestershire
Type of case:	Misconduct
Panel members:	Wayne Miller (Chair, Lay member) Mary Scattergood (Registrant member) Georgina Wilkinson (Lay member)
Legal Assessor:	Jayne Salt (31 July – 4 August 2023) Breige Gilmore (7 August 2023) Ben Stephenson (24 – 25 August 2023)
Hearings Coordinator:	Khadija Patwary
Nursing and Midwifery Council:	Represented by Simon Gruchy, Case Presenter (31 July – 7 August 2023) Represented by Rakesh Sharma, Case Presenter (24 – 25 August 2023)
Mr Odukunle:	Not present and unrepresented
Facts proved:	Charges 1), 2)b), 2)c), 2)d), 3)a) and 3)b)
Facts not proved:	Charges 2)a)i) and 2)a)ii)
Fitness to practise:	Impaired

Sanction:	**Suspension order (12 months)**
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 Odukunle was not in attendance and that the Notice of Hearing letter had been sent to Mr Odukunle's registered email address by secure email on 29 June 2023.

Mr Gruchy, 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.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Odukunle's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Odukunle 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 Odukunle

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

Mr Gruchy referred the panel to an email from Mr Odukunle dated 6 June 2023 in which he stated that:

> *'My name is Adeniyi Odukunle. I was informed that you requested for my contact detail. I have informed RCN that I do not wish to engage with NMC as I no longer practice as a nurse or engaged in any regulated healthcare profession.*
>
> *I have stopped practicing as a nurse or engaged in any healthcare profession since 2020 and I have no intention of working as a nurse anymore.'*

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 Odukunle. In reaching this decision, the panel has considered the submissions of Mr Gruchy 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 Odukunle;
- Mr Odukunle has 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 scheduled to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in April 2020;
- 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 Odukunle in proceeding in his absence, although the evidence upon which the NMC relies will have been sent to him to his registered email address. Mr Odukunle will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give 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 Odukunle's decisions 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 these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Odukunle. The panel will draw no adverse inference from Mr Odukunle's absence in its findings of fact.

Details of charge

That you, on 8 April 2020, in your capacity as a Support Worker at Redhouse Care Home (the Home):

1) Did not read Resident A's care plan and/or behaviour plan prior to providing them with support despite being required to do so. **(proved)**

2) Your interaction with Resident A was inappropriate in that you aggravated and/or did not prevent the situation from escalating further in one or more of the following ways:
   a) You did not seek assistance from a senior member of staff when Resident A: **(not proved in its entirety)**
      i) did not comply with your requests to leave the DVDs/CDs;
      ii) began to verbally abuse you.
   b) On one or more occasion you ignored Colleague B's instruction that you go into a different room; **(proved)**
   c) You did not attempt to disengage from the interaction when Resident A started verbally abusing you; **(proved)**
   d) You walked towards Resident A after they had begun verbally abusing you; **(proved)**

3) Physically assaulted and/or roughly handled Resident A in that you: **(proved in its entirety)**
   a) Kicked or, in the alternative, forcefully swept Resident A's legs;
   b) Forcefully held Resident A's arms to the ground.

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

Decision and reasons on application to admit the hearsay evidence of Ms 1

The panel heard an application made by Mr Gruchy under Rule 31 to allow the hearsay testimony of Ms 1 into evidence. Despite some attempts, the NMC had not been able to obtain a signed, written statement from Ms 1.

In an email to the NMC dated 20 July 2023, Ms 1 stated that:

> *"You had previously requested that I provided a written statement, but I do not feel that it is appropriate to provide a statement as this pre- dates my employment at Accomplish Group.*
>
> *I have not stated that the care plans do not exist. I did confirm that the care plans are 'live' documents and updated as and when required by the Service.*
>
> *You are welcome to produce a written statement exhibiting the documents that I have provided you to date."*

Mr Gruchy submitted that the evidence in relation to the appendices referred to in Witness 3's witness statement and Mr Odukunle's training record is highly relevant and though not provided during the course of the NMC's investigation, was produced for the purpose of the internal investigations. Mr Gruchy submitted that the emails relating to the missing appendices dated between 12 and 19 June 2023 and the emails relating to Mr Odukunle's training record dated 17 July 2023 is not the sole and decisive evidence. The training record supplied go as far to address charge 2). He submitted that there's a means of testing the reliability of the evidence as the panel is due to hear oral evidence from Witness 3. He further submitted that there is no suggestion that Ms 1 would have any reason to fabricate the information she has provided. Mr Gruchy advanced the argument that there was no lack of fairness to Mr Odukunle in allowing Ms 1's hearsay testimony into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is "*fair and relevant*", a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered whether Mr Odukunle would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 1 to that of allowing hearsay testimony into evidence.

It considered the hearsay evidence to be relevant to charges 2) and 3), but it was not the sole and decisive evidence. The panel noted that Mr Odukunle had not had sight of these documents and as Mr Odukunle had voluntarily absented himself from the proceedings, he would not have the opportunity to question their content. There was also public interest in the issues being fully explored which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Ms 1 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

At the time in question, Mr Odukunle was not a registered nurse, having entered the register in August 2020. However, under Article 22(3) of the Nursing and Midwifery Order 2001, the NMC is not prevented from considering concerns that arose at a time when the person against whom the allegation is made was not registered. As a result, the NMC has jurisdiction to consider the regulatory concern in this case.

The charges arose whilst Mr Odukunle was working as a bank support worker for Accomplish Group at the Home.

It is alleged that on 8 April 2020, Mr Odukunle was involved in an altercation with Resident A at the Home. Resident A was noted as being quite independent but needing one to one care for challenging behaviour and for stimulation. Mr Odukunle was providing care to Resident A at the Home and as a support worker, he was expected to be familiar with Resident A's care plan and behavioural plan before starting the shift.

Resident A's behaviour plan stated that if he was "*off baseline*", staff should remain calm and use a "*low arousal approach*" at all times. Staff should recognise warning signs and employ distraction techniques as early as possible to prevent incidents from taking place. If this was not helping, staff should reduce interaction and allow space to allow Resident A to calm.

The incident started when Resident A was taking DVDs/CDs from a shed outside and was giving them to another resident and bringing them into a communal area. It is alleged that Mr Odukunle told Resident A to stop bringing the DVDs/CDs inside. Resident A then went back to the shed and started throwing the DVDs/CDs. It is further alleged that Mr Odukunle shouted at Resident A and told him to go upstairs. Resident A refused to come inside and went back into the garden. It is alleged that Mr Odukunle shouted at Resident A, at which point he was asked by one of his colleagues, Colleague B, to come inside to leave Resident A to calm down, as she could see that Resident A was "*going to kick off*"".

Mr Odukunle allegedly had the opportunity to walk away from the situation but chose not to do so.

Resident A then began shouting at Mr Odukunle and making racially offensive comments. Colleague B again asked Mr Odukunle to leave, but instead he allegedly walked towards Resident A. At that point, Resident A went to punch Mr Odukunle. It is alleged that Mr Odukunle rather than guarding himself or removing himself from the situation, caught hold of Resident A's hands, then kicked or swept at Resident A's legs, causing him to fall to the floor. Mr Odukunle then held Resident A down until assistance came.

Mr Odukunle was sent home from work after the incident and was suspended the following day. Mr Odukunle was dismissed for gross misconduct on 15 June 2020. He had appealed this decision, however it was rejected.

Mr Odukunle is not currently working as a nurse.

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 Gruchy on behalf of the NMC.

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

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:

- Colleague B: Agency Support Worker at the Home at the time of the allegations;
- Witness 2: Registered Manager at Boston House in Oldham at the time of the allegations and currently Safeguarding Lead for Accomplish;
- Witness 3: Registered Manager at the Home and Holly House Care Home (Holly House Care) at the time of the allegations;
- Witness 4: Healthcare Assistant at the Home at the time of the allegations.

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

Charge 1)

1) Did not read Resident A's care plan and/or behaviour plan prior to providing them with support despite being required to do so.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's, Witness 3's and Witness 4's witness statements and oral evidence. The panel also took into account Mr Odukunle's signed account of the incident dated 29 April 2021 and the disciplinary hearing minutes dated 4 June 2020 and 12 June 2020.

At the outset, the panel established that Mr Odukunle had a duty to read Resident A's care plan and/or behaviour plan prior to providing them with support as it heard oral evidence from Colleague B, Witness 3 and Witness 4 that Mr Odukunle was required to do this.

The panel considered Colleague B's oral evidence in which she advised that all staff must read the PBS plans for service users. She advised that as support staff, it is within the job description to read them, describing it as a "*basic rule of looking after someone*".

The panel considered Witness 3's witness statement in which she stated that "*I found no evidence to suggest that the Nurse had reviewed this behaviour plan. I use 'read, understand and sign' forms in my service to confirm that a member of staff has reviewed a behaviour plan. However these were not in place at the Home until after I arrived…*"

This was further supported by Witness 4's oral evidence in which she stated that "*it was part of the duties as the shift leader allocated times to both filling documentation and read the records. The care plan and behaviour support plan especially for working 1:1*."

The panel also considered Mr Odukunle's signed account dated 29 April 2021 in which he stated that *"On the allegation that I failed to read the service user care plan, I regret this action as I erroneously trusted the managers of Red house at that time who give verbal briefing to staff and never made available service user care plan. I should have insisted on reading the care plan when I asked for it the first time I was called to work in Red house and the manager gave me a verbal briefing about the service user. I admitted this is an error on my part and have learned from it."* Further, in two disciplinary hearing meetings dated 4 June 2020 and 12 June 2020, he stated he did not read the PBS plans for Resident A.

On that basis, the panel was satisfied on the balance of probabilities that Mr Odukunle did not read Resident A's care plan and/or behaviour plan prior to providing them with support despite being required to do so.

In light of the above, the panel therefore finds charge 1) proved.

Charge 2)a)i)

2) Your interaction with Resident A was inappropriate in that you aggravated and/or did not prevent the situation from escalating further in one or more of the following ways:
    a) You did not seek assistance from a senior member of staff when Resident A:
        i) did not comply with your requests to leave the DVDs/CDs;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's witness statement and oral evidence. It also took into account Witness 2's oral evidence.

During Witness 3's oral evidence the panel had asked her whether it was normal to seek assistant from a senior member of staff when someone was not complying to something such as leaving DVDs/CDs alone. Witness 3 told the panel that "*not necessarily I would say no. If there was a danger, and you were unable to manage that then you might seek another member of staff. Especially a senior but not for something so trivial*." The panel noted that Witness 3's evidence in relation to this incident was consistent and credible due to her role as a manager of the Home.

The panel determined that in the absence of any other evidence, it could not be satisfied on the balance of probabilities that Mr Odukunle's interaction with Resident A was inappropriate in that he aggravated and/or did not prevent the situation from escalating further in not seeking assistance from a senior member of staff when Resident A did not comply with his requests to leave the DVDs/CDs.

In light of the above, the panel therefore finds that the NMC has not discharged its burden of proof and finds charge 2)a)i) not proved.

Charge 2)a)ii)

2) Your interaction with Resident A was inappropriate in that you aggravated and/or did not prevent the situation from escalating further in one or more of the following ways:
   a) You did not seek assistance from a senior member of staff when Resident A:
      ii) began to verbally abuse you.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague B's and Witness 3's witness statements and oral evidence. It also took into account Witness 2's oral evidence.

During Colleague B's oral evidence, the panel had asked her when did the racial abuse start and Colleague B told the panel that "*It started in the garden and then it went on. It was not uncommon for the resident to say those things as he did not have a filter*." The panel considered that as this was common for Resident A, it is unlikely to be the subject of complaint or assistance by Mr Odukunle under normal circumstances.

During Witness 3's oral evidence the panel had asked her is it normal to seek assistance from a senior member of staff when residents verbally abuse a staff member. Witness 3 told the panel that "*I suppose in terms of a debrief yes, if it was something the staff needed but not ordinarily*."

The panel determined that in the absence of any other evidence, it could not be satisfied on the balance of probabilities that Mr Odukunle's interaction with Resident A was inappropriate in that he aggravated and/or did not prevent the situation from escalating further in not seeking assistance from a senior member of staff when Resident began to verbally abuse him.

In light of the above, the panel therefore finds that the NMC has not discharged its burden of proof and finds charge 2)a)ii) not proved.

Charge 2)b)

2) Your interaction with Resident A was inappropriate in that you aggravated and/or did not prevent the situation from escalating further in one or more of the following ways:
    b) On one or more occasion you ignored Colleague B's instruction that you go into a different room;

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement, Colleague B's supplementary witness statement and oral evidence. It also took into account Colleague B's handwritten statement dated 8 April 2020, the note of the telephone call between Witness 3 and Mr Odukunle dated 25 May 2020, the disciplinary hearing minutes dated 4 June 2020 and 12 June 2020 and Mr Odukunle's signed account of the incident dated 29 April 2021.

The panel considered Colleague B's witness statement in which she stated that:

> "*I told the Nurse at least three times to go in to a different room, away from Resident A, but the Nurse ignored me. I asked this in a very basic way as an instruction based on my experience and initiative in working with Resident A, as well as the notes in their care plan regarding exhibiting challenging behaviour. I told the Nurse that I could see Resident A was going to kick off and they did."*

The panel considered Colleague B's supplementary witness statement in which she stated that:

> "*At paragraph 11 of my original statement, I say that I told the nurse at least three times to go into a different room but he ignored me. I first told the nurse this whilst he was outside. Eventually he did go inside and stood in the lounge area. Resident A also came inside to the lounge area. From memory Resident A was going in and out of the lounge with the DVDs he had taken from the shed. The nurse was trying to stop Resident A from bringing in the DVDs. I cannot remember how many times Resident A went in and out of the lounge. If I remember correctly, the nurse was not shouting from inside the lounge to Resident A outside. At that point it was when Resident A came into the lounge that the nurse would tell him off*" and "*I believe it was after the third or fourth time that I told the nurse to stop, and I was kind of standing with him near the door to usher him out of the lounge…*"

The panel noted that this was corroborated by Colleague B's handwritten statement dated 8 April 2020 in which she stated that:

> "*I asked [Mr Odukunle] to come inside and leave Resident A to come in the garden, Resident A started shouting racial abuse to [Mr Odukunle] and telling him to "fuck off." I asked [Mr Odukunle] to go to a different room so Resident A could calm down but [Mr Odukunle] went to the door which Resident A was walking to I again asked [Mr Odukunle] to remove himself from the situation*."

The panel was of the view that Colleague B's account in regard to this incident was consistent and credible in that Colleague B gave direct instructions to Mr Odukunle whilst being assertive with her voice. The panel noted from Colleague B's oral evidence that she was in the same room as Mr Odukunle, in close proximity to him and that she was looking straight at him.

The panel considered the telephone call between Witness 3 and Mr Odukunle. Witness 3 had asked Mr Odukunle whether he was asked to remove himself by other staff when Resident A was becoming heightened. Mr Odukunle told her that "*yes, can't remember the female staff's name but she told me to get away from Res A when he was aggressive possibly more than once*."

The panel noted Mr Odukunle's statement in which he stated that "*the other staff was (sic) in the lounge and I heard her calling to me to come into the lounge which I was already doing*". It further noted that in the disciplinary meeting minutes Mr Odukunle states that he was asked to leave "*only once, it was not three, he (sic) said Julius come inside*". The panel noted this was inconsistent with the evidence of a phone call between Witness 3 and Mr Odukunle, where he states, "*possibly more than once*". The panel also noted that they had tested both Colleague B and Witness 3's evidence, which was clear and consistent. The panel therefore preferred the evidence of Colleague B and Witness 3.

On that basis, the panel was satisfied on the balance of probabilities that Mr Odukunle's interaction with Resident A was inappropriate in that he aggravated and/or did not prevent the situation from escalating further on one or more occasion he ignored Colleague B's instruction that he go into a different room.

In light of the above, the panel therefore finds charge 2)b) proved.

Charge 2)c)

2) Your interaction with Resident A was inappropriate in that you aggravated and/or did not prevent the situation from escalating further in one or more of the following ways:
   c) You did not attempt to disengage from the interaction when Resident A started verbally abusing you;

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement, Colleague B's supplementary witness statement and oral evidence. It also took into account the note of the telephone call between Witness 3 and Mr Odukunle dated 25 May 2020 and the incident report dated 9 April 2020, which included a statement from Mr Odukunle.

The panel considered Colleague B's witness statement in which she stated that:

> "*Resident A started shouting racial abuse at the Nurse based on the colour of the Nurse's skin. I cannot remember exactly what was said but I think Resident A called the Nurse a 'black bastard'. The Nurse responded to these comments by going up to Resident A, as although they were both in the lounge area the Nurse was roughly two metres away from Resident A, telling him no and that it was not okay in*

some kind of way, although I cannot remember exactly how. It was a reaction I would expect if these comments had been raised in any other circumstance. However the Nurse needed to remember where they were. At this stage, the Nurse did not attempt to disengage" and *"The Nurse did not walk away from Resident A at this point. They were both in front of the sofa situated in the bay window area where the door to the garden is. Resident A was facing the Nurse an attempted to punch them. The punch was not aimed anywhere specific. Again, the Nurse did not attempt to disengage here…"*

The panel also considered Colleague B's oral evidence in which she told the panel that "*He wasn't trying to disengage or move away he was trying to get the resident to follow him. The racial abuse and swearing continued and the nurse walked directly up to Resident A*." In further questions from the panel, Colleague B told the panel that "*He should have left the resident to calm down, you are in their house if they are frustrated or escalating you should leave*."

The panel was of the view that this incident is more likely to have happened very quickly between what had occurred in the garden to then coming into the lounge. There are some doubts where this incident had started however, whether this had started in the garden or the lounge. Mr Odukunle had an opportunity to disengage when this started.

The panel considered Mr Odukunle's statement in the incident report dated 9 April 2020 in which he stated:

"*He [resident A] stopped and moved away from the shed and started shouting "I am sick and tired of being ordered around by a n***, you sick c***". I moved away from him in the garden and came in to the lounge*."

The panel also considered the telephone call notes between Witness 3 and Mr Odukunle in which it is stated "*Julius stated the staff told him to step away for his own safety, so Julius came into the lounge from the door to the garden and this is when res A (sic) started swinging punches at him.*" The panel was of the view that this was consistent

evidence, however, it had not been tested by the panel. The panel noted that it had tested the evidence of Colleague B which was clear and consistent. The panel therefore preferred the evidence of Colleague B.

On that basis, the panel was satisfied on the balance of probabilities that Mr Odukunle's interaction with Resident A was inappropriate in that he aggravated and/or did not prevent the situation from escalating further on one or more occasion he did not attempt to disengage from the interaction when Resident A started verbally abusing him.

In light of the above, the panel therefore finds charge 2)c) proved.

Charge 2)d)

2) Your interaction with Resident A was inappropriate in that you aggravated and/or did not prevent the situation from escalating further in one or more of the following ways:
   d) You walked towards Resident A after they had begun verbally abusing you;

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement, Colleague B's supplementary witness statement and oral evidence. It also took into account Mr Odukunle's signed account of the incident dated 29 April 2021.

The panel considered Colleague B's supplementary witness statement in which she stated that:

> "*I believe it was after the third or fourth time that I told the nurse to stop, and I was kind of standing with him near the door to usher him out of the lounge, when Resident A 'followed' the nurse and began to shout racial abuse. This was when the nurse went up to Resident A. I do not think that the nurse walking up to*

Resident A was done in a 'negative' way e.g., to intimidate him. Nonetheless, considering the circumstances and Resident A's behaviour, it was inappropriate."

The panel considered Colleague B's oral evidence in which she stated "*the registrant walked back on himself towards the resident*".

The panel considered Mr Odukunle's signed account of the incident dated 29 April 2021 of his and Resident A's movements but determined that this lacked clarity. The panel, therefore, preferred the evidence of Colleague B.

On that basis, the panel was satisfied on the balance of probabilities that Mr Odukunle's interaction with Resident A was inappropriate in that he aggravated and/or did not prevent the situation from escalating further on one or more occasion he walked towards Resident A after they had begun verbally abusing him.

In light of the above, the panel therefore finds charge 2)d) proved.

Charge 3)a)

3) Physically assaulted and/or roughly handled Resident A in that you:
   a) Kicked or, in the alternative, forcefully swept Resident A's legs;

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement, Colleague B's supplementary witness statement and oral evidence. It also took into account Witness 2's, Witness's 3 and Witness 4's witness statements and oral evidence, Colleague B's handwritten statement dated 8 April 2020, Mr Odukunle's handwritten statement dated 8 April 2020 and Mr Odukunle's signed account of the incident dated 29 April 2021 and the position he took during the local investigation.

The panel considered Colleague B's witness statement in which she stated that "*…I do not think that the kick was intentional but instead was more defensive as Resident A had attempted to punch the Nurse*." It also considered Colleague B's handwritten statement dated 8 April 2020 in which she stated that Mr Odukunle "*…grabbed Resident A by the hands and kicked Resident A's legs…*" In her oral evidence, Colleague B also told the panel that she was not far from Mr Odukunle, she was only five foot away from him and that she had witnessed the whole incident as the room was empty.

In response to the panel's question, Witness 3 told the panel that "*I cannot see it would ever be appropriate unless you were trapped in a corner and someone had a knife, but in this situation the environment allowed you to escape.*" The panel also considered Witness 3's oral evidence in which she told the panel that "*it was quite distressing and not appropriate for Mr Odukunle to do that*."

During oral evidence Witness 2 told the panel that "*no training would suggest the sweeping of the leg and no reason to put hands on the resident, it doesn't make sense*."

Witness 4 in her written statement refers to a conversation she had with Resident A on 9 April 2020. In a statement provided by Witness 4 in the incident report dated 9 April 2020 she stated that Resident A told her "*Julius grabbed me by my hands and kicked my feet from under me and I fell to the floor.*" In her oral evidence Witness 4 advised that she felt Resident A's response was genuine and that he appeared frightened that Mr Odukunle was due to start shift that evening.

The panel further considered Mr Odukunle's signed account of the incident dated 29 April 2021 in which he stated that "*I never kicked his leg off of the ground, and this is not the first time he had attacked me and the managers at the time were aware. There was no physical evidence or mark on the service user because I did not assault him*." The panel was of the view that Mr Odukunle has been consistent throughout his accounts that he did not assault Resident A. However, the evidence by Colleague B and Witness 4 corroborate

each other and have been consistent both in written and oral evidence. For this reason, the evidence of Colleague B and Witness 4 is preferred.

The panel took into account Mr Odukunle's training record which indicated that he had attended Proact SCIPr training and Witness 4's oral evidence that the Home had moved away from that training as it focused too much on physical intervention. The panel had no evidence of what was involved in that training. However, it took into account the evidence of Witnesses 2, 3 and 4 that although they did not know precisely what techniques were taught in the Proact SCIPr training, they could not envisage that any training would include leg sweeps.

On that basis, the panel was satisfied on the balance of probabilities that Mr Odukunle did physically assault and/or roughly handled Resident A in that he kicked or, in the alternative, forcefully swept Resident A's legs.

In light of the above, the panel therefore finds charge 3)a) proved.

Charge 3)b)

3) Physically assaulted and/or roughly handled Resident A in that you:
    b) Forcefully held Resident A's arms to the ground.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's, Witness 2's, Witness 3's and Witness 4's witness statements and oral evidence. It also took into account Mr Odukunle's signed account of the incident dated 29 April 2021 and Accomplish Group's Policy: Supporting People with Behaviours of Concern dated 30 August 2019.

The panel considered all the written evidence and acknowledged that there was a consensus on the holding of Resident A's hands whilst on the floor.

The panel considered Colleague B's witness statement in which she stated that:

> "*The Nurse held Resident A down on the floor by their arms. I think there was quite a lot of force used to restrain Resident A as they were really strong. Resident A was trying to squirm out of the Nurse's restraint and was shouting at the Nurse. I do not remember what Resident A was shouting as I was trying to call for help. I am also not aware of how the Nurse reacted to this."*

This was corroborated by Mr Odukunle's signed account of the incident dated 29 April 2021 in which she stated that "*I held his hands to prevent him from harming me. He came at me after I left him walking towards the kitchen and I do not know he had followed. I never walked towards him*."

The panel heard differing oral evidence when questioning each witness in relation to reasonable force. Colleague B who witnessed the incident told the panel that "*at this point holding his hands down it was reasonable force, he was on top of the resident, I suppose so as they were in close contact at the time*." It considered Witness 2's oral evidence in which he told the panel that "*it's not reasonable force to hold hands down and there was no reason to put hands on the resident*, *I can tell you this behaviour would not be in any plan with certainty*."

The panel also considered Witness 3's oral evidence in which she told the panel that "*if the resident is on the floor, I don't see why you would need to hold the hands down. This is not reasonable force. The environment was built for escape*. *The person is not particularly quick this was not necessary*." The panel further considered Witness 4's oral

evidence in which she told the panel that "*…nor holding hands down we are never taught restraint*."

The panel was satisfied on the balance of probabilities that Mr Odukunle did physically assault and/or roughly handled Resident A in that he forcefully held Resident A's arms to the ground.

In light of the above, the panel therefore finds charge 3)b) 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 Odukunle'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 Odukunle'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.'*

Mr Gruchy 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 Gruchy submitted that charges 1) and 2) demonstrate conduct which may amount to an attitudinal problem. He submitted that if it not for charges 1) and 2), charge 3) would not exist. He submitted that the charges and the breaches do fall short of the professional standards of what is expected of a professional nurse. He submitted that there was a failure of Mr Odukunle to familiarise himself and understand the needs of the resident. Mr Gruchy submitted that in this circumstance the resident was clearly distressed in which Mr Odukunle did not deescalate the situation but by continuing to approach the resident may have had an effect of aggravating the situation. He submitted that the physical intervention involving rough handling amounted to serious professional misconduct.

Submissions on impairment

Mr Gruchy 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 cases of *Council for*

Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin).

Mr Gruchy submitted that Mr Odukunle's fitness to practice is impaired by way of public protection and is in the public interest. He submitted that there is evidence of actual harm to Resident A as there was reference to a cut and a sore head as well as the distress that was caused. He submitted that Witness 4 had stated that the resident was still scared the following morning of the incident. Mr Gruchy submitted that Mr Odukunle has underlying attitudinal issues and that there is insufficient insight into the seriousness of his conduct. However, Mr Gruchy acknowledged that there is some insight by virtue of Mr Odukunle's most recent signed document. In respect of charge 3), he submitted that Mr Odukunle has demonstrated no insight as he still denies this charge. Mr Gruchy submitted that Mr Odukunle has also not demonstrated any safe practice and that his failings are a serious departure from what is expected of a registered nurse. He submitted that there was no evidence of further relevant training provided by Mr Odukunle, and that there was insufficient insight and lack of remediation.

Mr Gruchy acknowledged this was an isolated incident and acknowledged the potential cultural context within the Home. In response to panel questioning regarding Mr Odukunle not being a registered nurse at the time of the incident, Mr Gruchy submitted that it mattered not, as Mr Odukunle had not familiarised himself with the needs of the resident. He submitted that this shows a fundamental attitudinal problem as it was incumbent upon anyone working at the Home to familiarise themselves with the care needs of anyone they had a duty of care for.

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (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 Odukunle's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Odukunle'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

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

2.6 recognise when people are anxious or in distress and respond compassionately and politely

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.4 take account of your own personal safety as well as the safety of people in your care

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

To achieve this, you must:

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

In relation to charge 1), the panel was of the view that this amounted to misconduct. If Mr Odukunle had read the plans he would have been in a much better position to both care for Resident A and deal with this incident. It noted that Mr Odukunle had a duty to make himself familiar with residents' documentation at the Home in order to provide them with appropriate care and that staff members at the Home were required to do this. The panel considered that Mr Odukunle disregarded the care plan. The onus was on Mr Odukunle to read Resident A's documentation as the support worker. The panel also noted that this was not a one off error, Mr Odukunle had not read the care plan on more than one occasion whilst working with the resident. The panel acknowledged that Mr Odukunle in his signed account dated 29 April 2021, stated "*I admitted this is an error on my part.*"

In respect of charges 2)b) and 2)c), the panel noted that Mr Odukunle had ignored Colleague B's instructions on a number of occasions. It was incumbent on him to follow that instruction, for the care of Resident A, by ignoring it he unnecessarily escalated the situation. In relation to charge 2)c), the panel recognised that Mr Odukunle was being verbally racially abused. However, challenging behaviour is a feature in the environment that he was working in which includes verbal racial abuse. Mr Odukunle should have disengaged from the situation that had occurred and had the opportunity to do so. Therefore, this amounts to misconduct. Mr Odukunle's actions in relation to these charges amounted to serious departures from acceptable standards expected of a registered nurse.

In respect of charge 2)d), the panel was of the view that this amounted to misconduct. Mr Odukunle escalated the situation and responded emotionally and physically to the verbal abuse from Resident A, to the contrary Mr Odukunle had the opportunity to remove himself from the situation but chose not to. It noted that in the circumstance, there was no good reason for Mr Odukunle to walk towards Resident A. It further noted that Mr Odukunle failed to remain professional. Mr Odukunle's action in relation to this charge amounted to serious departure from acceptable standards expected of a registered nurse.

In relation to charges 3)a) and 3)b), Mr Odukunle's physical actions put Resident A onto the floor. The panel heard from Colleague B and Witness 3 that this was distressing and Witness 2 said that there was no reason to put hands on Resident A as this was not reasonable force. The panel was of the view that Mr Odukunle roughly handled Resident A who was vulnerable and that this was inappropriate behaviour which caused actual harm. Mr Odukunle had a number of opportunities to leave the lounge which he did not. The panel determined that a nurse is expected to be professional at all times and Mr Odukunle's actions in charges 3)a) and 3)b) would by the standards of ordinary people, and fellow professional nurses, be judged to be deplorable falling far below the expected standards of a registered nurse.

Resident A had the right to receive safe and compassionate care, Mr Odukunle's actions meant that this was severely lacking. The panel found that Mr Odukunle's conduct with respect to charges 1), 2)b), 2)c), 2)d), 3)a) and 3)b) 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 Odukunle''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 and to maintain professional boundaries. Residents and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

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

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

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

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

d) *...'*

The panel found that Resident A was put at risk and was caused physical and emotional harm as a result of Mr Odukunle's misconduct. Mr Odukunle's misconduct had breached the fundamental tenets of the nursing profession and also brought its reputation into disrepute. It went on to consider whether there may be a risk of repetition and in doing so it assessed Mr Odukunle's current insight, remorse and remediation.

Regarding insight, the panel determined that Mr Odukunle's insight is limited. The panel noted that Mr Odukunle has expressed regret for not reading Resident A's care plan and/or behaviour plan. However, he did not recognise how his conduct has impacted negatively on the reputation of the nursing profession or on Resident A and that he has not demonstrated an understanding of the serious nature of his failings. The panel noted that Mr Odukunle did not take responsibility for failing to disengage or leave the room to let another staff member to handle the situation.

In relation to remorse, the panel noted that Mr Odukunle did not demonstrate any remorse in his signed account dated 29 April 2021. The panel was satisfied that the misconduct is capable of remediation. The panel carefully considered the evidence before it in determining whether or not Mr Odukunle has strengthened his practice. The panel was of

the view that there is no evidence of any relevant training since the incident. The panel further considered that there is no evidence of remediation.
The panel recognise the racial abuse that was directed towards Mr Odukunle and believe that this negatively impacted on the working environment at that time. The panel believes that this racial abuse understandably had a negative impact on the registrant and may have contributed to the manner in which he conducted himself at that time. This however does not negate the professional responsibilities expected of the registrant at this time and his subsequent actions were neither necessary nor proportionate in the circumstances.

The panel considered the context in which the incidents occurred. In relation to the racism experienced by Mr Odukunle the panel considered that there was no evidence of support or supervision offered to Mr Odukunle by Accomplish in relation to this distressing aspect of his work and the likely impact it had on him. The panel noted that the Home did not have a full-time manager at the time, had many agency staff and was going through a transitional period. The panel understood that the training at the Home needed to be refreshed and there was no consistency with the guidelines and policies which Accomplish had put in place. The panel noted that the Home managers had provided Mr Odukunle with training on how to support people with behaviours of concern, but this was allowed to lapse and had not ensured Mr Odukunle's training was up to date, as per the Accomplish policy. The panel also noted that there was a concern about the culture at the Home and that COVID-19 may have impacted the staff members and residents at the Home.

Taking all these matters into account the panel considered that there is no evidence before it to demonstrate meaningful insight or strengthened practice on Mr Odukunle's part. The panel consider that there is a substantial risk of repetition of the matters found proved. The panel is satisfied that currently Mr Odukunle is unable to practice kindly, safely and professionally. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mr Odukunle's registration has been suspended.

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 Sharma, in his written submissions dated 24 August 2023, stated that:

1. *'As the panel will be aware, the NMC has produced guidance as to the approach to be taken to sanction. That guidance can be found on the NMC's website. These submissions serve to supplement but in no way replace that guidance.*

2. *It is accepted that each case will turn on its own unique facts and further accepted that the guidance does not lay down a rigid tariff nor serve as a substitute for legal advice.*

3. *When considering how to approach the guidance, it is submitted that, the panel may find of assistance the comments of Collins J in Leeper:*

   '[the GMC's indicative sanctions guidance] helps to achieve a consistent approach to the imposition of penalties where serious professional misconduct is established. The [panel] must have regard to it although obviously each case will depend on its own facts and guidance is what it says and must not be regarded as laying down a rigid tariff'.

4. *When considering sanctions the panel should have regard to their purpose. Sanctions are not intended to be punitive, although they may have that effect but rather they are intended to protect the public and the public interest.*

5. *Having found the registrant's fitness to practice impaired on the grounds of public protection and public interest, the next question for the panel is what the appropriate sanction in this case, if any, is.*

6. *Protection of the public should take little explanation and is self-explanatory however looking to define the public interest; the public interest is commonly defined as encompassing three strands, namely:*

    a. *Protection of patients and others.*
    b. *Maintenance of public confidence in the professions and the regulatory body.*
    c. *Declaring and upholding proper standards of conduct and behaviour.*

7. Panels make their decision by considering all the sanctions available to them and start by considering whether the least restrictive sanction would be sufficient to protect the public and uphold the public interest in light of those factors. If the least restrictive sanction is not sufficient, the panel will work through the available sanctions in ascending order of severity, until they find the order that is considered sufficient.

8. It is submitted that, to ensure the sanction imposed is not disproportionate, the panel should consider each sanction in ascending order and not simply arrive at the chosen sanction by the process of elimination; rather, specific reasons should be given as to why the chosen sanction is no more than necessary, something which may include a consideration and rejection of the next most severe sanction.

9. The panel should always have in mind the need to act proportionately. Accordingly, when considering sanction the panel should balance the interests of the public against those of the Registrant. It should be satisfied that any interference with the Registrant's right to practice is no more than is necessary in the circumstances. However, as set out in Bolton v Law Society, '[t]he reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.'

Aggravating/Mitigating Factors

10. As the principal function of sanctions is not punitive but to protect the public it follows, as in the case of Bolton, that 'since the professional body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction'.

11. Although potentially of less weight in this jurisdiction, the panel should still have careful regard to any evidence of mitigation when deciding on sanction.

12. As well as considering any mitigating features of the case, the panel will need to consider any aggravating features of the case.

13. When considering the aggravating and mitigating features of this case, it is submitted that, the panel should not simply list them but rather should indicate in terms how they have impacted on the suitability of whatever sanction is arrived at.

14. The Registrant has not engaged with this hearing therefore you have not had the benefit of hearing directly from him. You have seen the various response provided by the Registrant covering some of the areas of concern at earlier stages including at local level. To the extent that these responses relate to specific charges, you may wish to take account of them.

15. Whilst not a mitigating factor, it is only fair I inform the panel that the Registrant has no previous regulatory findings recorded against him therefore the seriousness of this case is not raised by such matters. This must be balanced by the fact the misconduct in these charges was committed during the period immediately prior to the Registrant entering the Register therefore no time of safe and competent practise had, in fact elapsed.

16. In our submission the panel may consider the following to be aggravating factors: The vulnerability of the patient, the risk of patient harm, the effect on others who did or may have witnessed the misconduct.

Submission

17. The panel will consider whether this matter could be dealt with by way of taking no further action but it is submitted that this case is too serious to be addressed by this option. The NMC's main concerns if no action were to be taken would be the lack of protection afforded to patients and sending entirely the wrong message to both the public and fellow registered professionals. In our submission these are serious matters requiring a robust sanction.

18. In considering whether a caution order would be appropriate, the panel will have to evaluate any insight shown by Mr Odukunle. In our submission, there is no evidence of developed insight in this case. We also submit that the conduct found proved in this case is too serious to be dealt with by a caution order.

19. We submit that a conditions of practice order is not appropriate. There are very limited identifiable areas of the Registrant's practise which require further training and or evaluation. The main areas of concern which are evident from the escalation of this situation and the culmination of events being the physical assault of a patient would be impossible to adequately deal with by conditions. In our submission these concerns demonstrate a concerning deep seated attitudinal problem. In our submission it would not be possible to devise a package of conditions which would adequately protect the public and uphold standards.

20. The NMC sanction guidance suggests a suspension order may be appropriate where there is a single incident and there are no underlying attitudinal concerns. Although this case involved a single incident. There was a clear sequence of escalating behaviour. It is this escalation culminating in physical assault which we say tends to support the submission that this is a Registrant who has a harmful deep seated attitudinal problem and which we have seen no evidence of his insight into. For these reasons, in our submission a suspension order is not suitable.

21. The conclusion we reach is that a striking off order is appropriate. The Registrant was responsible for serious professional misconduct including physical assault of a vulnerable resident and has shown no insight. No relevant remediation has been undertaken to strengthen his practice or address the concerning misconduct and we have concerns regarding his underlying attitude towards these matters.

The NMC therefore submit that the appropriate sanction is a ***Striking Off Order****.'*

Mr Sharma referred the panel to his written submissions and submitted that he did not deal with the element of racial abuse directed towards Mr Odukunle under the aggravating and mitigating factors. He submitted that it is a matter for the panel to consider if the racial abuse falls under mitigating factors. Mr Sharma submitted that the reason for the racial abuse not being included in the NMC's submissions under the mitigating factors is because of the "*but for*" test when looking at the facts of this case.

Mr Sharma submitted that the question is, but for the fact Mr Odukunle failed to remove himself at an early stage would this racial abuse either have happened at all, or if it did happen, would it have had any effect upon him? And if Mr Odukunle had in fact acted correctly and not committed this misconduct, Mr Sharma submitted that by removing himself at the earliest possible stage, that racial abuse either would not have been directed towards him, or if it had been, it would have been a fleeting moment of racial abuse as he was removing himself from the situation.

In response to a question from the panel, Mr Sharma submitted that although this event occurred before Mr Odukunle was on the NMC register, he was at a late stage in his training not long after he reached his qualification and entered onto the NMC register and that any training he had should have been fresh in his mind. He submitted that therefore this is neither a mitigating nor aggravating factor.

Decision and reasons on sanction

Having found Mr Odukunle'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:

- Abuse of a position of trust notwithstanding that the incident took place when Mr Odukunle was working as a support worker and before he demonstrated the required competence to become a registered nurse;
- Lack of meaningful insight; and
- Conduct which put Resident A at risk of more serious harm.

The panel also took into account the following mitigating features:

- COVID-19 infection prevention and control requirements at the time. The panel considered that Mr Odukunle may have been trying to comply and remove Resident A from a communal area;
- One off incident;
- Personal mitigation which is the verbal racial abuse; and

- Adherence to policy was not consistently enforced and training was allowed to lapse.

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

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining; and*
- *No evidence of general incompetence.*

The panel is of the view that there are no practical or workable conditions that could be formulated as Mr Odukunle has not been working as a nurse and has asserted that he does not intend to return to nursing practice in written correspondence.

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; and*
- *No evidence of repetition of behaviour since the incident.*

The panel considered that the misconduct in this case can properly be described as a single instance of misconduct. The panel has seen no evidence of repetition of behaviour since the incident. While the panel wishes to make clear that the misconduct by Mr Odukunle is wholly unacceptable the panel is not satisfied that it has any or sufficient evidence of a harmful deep-seated personality or attitudinal problems on Mr Odukunle's part. The panel has taken into account evidence of positive testimonials including registered nurses who supported Mr Odukunle's training.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. Further the panel considered that the public confidence in nurses, midwives and nursing associates could be maintained if Mr Odukunle was not removed from the register.

The panel having taken account of all the information before it, including the mitigation provided, concluded that it would be disproportionate to impose a striking-off order. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Odukunle's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship that such an order may cause Mr Odukunle. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case may be assisted by:

- Mr Odukunle's engagement/attendance;
- Written reflective piece on the impact of his misconduct;
- Testimonials from paid or unpaid work;
- Evidence of keeping up to date with nursing practice; and
- Mr Odukunle's indication of his future intentions.

Interim order

As the suspension 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 Odukunle's own interests until the suspension order takes effect.

Submissions on interim order

The panel considered the submissions made by Mr Sharma that an interim suspension order should be made to cover the appeal period. He submitted that an interim order is necessary to protect the public interest. He invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

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 to protect the public and otherwise in the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It considered that to not impose an interim order would be inconsistent with its earlier findings.

The panel considered imposing an interim conditions of practice order but determined that it would not be practicable or workable for the reasons set out in the substantive order consideration. Therefore, the panel made 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 substantive suspension order 28 days after Mr Odukunle is sent the decision of this hearing in writing.

This will be confirmed to Mr Odukunle in writing.

That concludes this determination.