Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Wednesday 12 October 2022 – Friday 21 October 2022,
Monday 27 March 2023 – Friday 31 March 2023

Virtual Hearing

Name of registrant:	**Saido Farah Abdi**	
NMC PIN:	12C0724E	
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 27 September 2012	
Relevant Location:	Westminster	
Type of case:	Misconduct	
Panel members:	Caroline Rollitt Lorna Taylor Shaun Donnellan	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	Sean Hammond	(Wednesday 12 October 2022 – Friday 21 October 2022)
	Michael Levy	(Monday 27 March 2023 – Friday 31 March 2023)
Hearings Coordinator:	Opeyemi Lawal	(Wednesday 12 October 2022 – Friday 21 October 2022)
	Chandika Cheekhoory-Hughes-Jones (Monday 27 March 2023 – Friday 31 March 2023)	
Nursing and Midwifery Council:	Represented by Madeleine Deasy, Case Presenter	

Mrs Abdi:	Present and not represented (on 12, 17 and 20 October 2022 only). Not present and not represented (on other listed days)
Facts proved:	Charges 1a, 1e**,** 2a, 2b, 3, 4, 5b, 6, and 7 in respect of charges 5b and 6
Facts not proved:	Charges 1b, 1c, 1d, 2c, 2d, and 5a
Fitness to practise:	Impaired
Sanction:	Striking-off order imposed
Interim order:	Interim suspension order (18 months)

Details of charge

"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;

1. *At around 13:15, extubated Patient A outside the scope of your competence, in that you carried out the extubation procedure;*
    a. *Alone.* **[PROVED]**
    b. *Whilst Patient A was still drowsy/sedated* **[NOT PROVED]**
    c. *Whilst Patient A had score of -1 on the Richmond Agitation-Sedation Scale* **[NOT PROVED]**
    d. *Without securing the Anchor Fast Straps to Patient A's face* **[NOT PROVED]**
    e. *Without securing/removing Patient A's Endotracheal Tube.* **[PROVED]**

2. *At around 14:00/14:30 did not escalate care for Patient A whilst they were unresponsive/deteriorating, in that you;*
    a. *Did not pull the crash bell in a timely manner* **[PROVED]**
    b. *Did not provide oxygen/conduct re-breathing/bagging in a timely manner* **[PROVED]**
    c. *Had prematurely removed Patient A's Anchor Fast Straps* **[NOT PROVED]**
    d. *Had prematurely deflated Patient A's Endotracheal Tube cuff* **[PROVED]**

3. *Administered propofol to Patient A after extubation/whilst they were not ventilated.* **[PROVED]**

4. *Administered propofol to Patient A without authorisation/supervision.* **[PROVED]**

5. *At around 16:48 retrospectively/inaccurately modified Patient A's ICIP records in that you;*

    a. *Retrospectively modified the cumulative volume of propofol administered to Patient A from 5ml/hr to 2ml/hr.* **[NOT PROVED]**
    b. *Retrospectively modified the rate of delivery of propofol to Patient A* **[PROVED]**

6. *Did not record that a bolus of 3.1ml at a rate of 900ml/h had been administered to Patient A at around 14:06.* **[PROVED]**

7. *Your actions in charge 5 a)* **[NOT PROVED]***, 5 b)* **[PROVED]** *& 6* **[PROVED]** *were dishonest as you sought to misrepresent the dose/volume/delivery rate of propofol administered to patient A.*

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

Decision and reasons on application for hearing to be held partially in private

On day 2 of the hearing, the panel heard evidence relating to [PRIVATE]. The panel decided, of its own volition, to hold the relevant parts of this hearing in private.

Ms Deasy, on behalf of the Nursing and Midwifery Council (NMC), did not object to the hearing being held partially in private for the reason identified by the panel.

The panel heard and accepted the advice of the legal assessor, including in relating to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Having heard that there will be reference to [PRIVATE], the panel determined to hold the hearing in private as and when such matters arise [PRIVATE].

Decision and reasons on application to amend the charge

On day 7 of the listed hearing days, after the NMC had concluded its case and after Mrs Abdi had given evidence, the panel heard an application by Ms Deasy to amend the wording of charges 1d and 1e.

Ms Deasy conceded that it would have been preferable for this application to have been made after the evidence of Ms 1 and before Mrs Abdi's evidence. She submitted that the proposed amendment would allow the charges to accurately reflect the alleged conducts as well as the evidence before the panel, and to remove charges that had no supporting evidence. Ms Deasy submitted that the proposed amendment would provide clarity. She further submitted that if the panel were minded to accept the proposed amendments in relation to charges 1d and 1e, she invited the panel to substitute the wording of charge 1d with the wording of charge 2c and to substitute the wording of charge 1e with the wording of charge 2d. She invited the panel to make no findings in respect to the original wording of charges 1d and 1e.

Ms Deasy submitted that the proposed amendments were as follows:

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*
>
> 1. *At around 13:15, extubated Patient A outside the scope of your competence, in that you carried out the extubation procedure;*
>   a. *Alone.*
>   b. *Whilst Patient A was still drowsy/sedated*
>   c. *Whilst Patient A had score of -1 on the Richmond Agitation-Sedation Scale*

d. ~~Without securing the Anchor Fast Straps to Patient A's face~~.
Had prematurely removed Patient A's Anchor Fast Straps

e. ~~Without securing/removing Patient A's Endotracheal Tube~~.
Had prematurely deflated Patient A's Endotracheal Tube cuff.

2. *At around 14:00/14:30 did not escalate care for Patient A whilst they were unresponsive/deteriorating, in that you;*
    a. *Did not pull the crash bell in a timely manner*
    b. *Did not provide oxygen/conduct re-breathing/bagging in a timely manner*
    ~~c. Had prematurely removed Patient A's Anchor Fast Straps~~
    ~~d. Had prematurely deflated Patient A's Endotracheal Tube cuff~~
    …

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was not in the interests of justice, especially as Mrs Abdi's is unrepresented. The panel determined that there would be prejudice to Mrs Abdi's and injustice would be caused by the proposed amendments being allowed. The panel determined that it was therefore not appropriate to allow the amendments at this late stage of the hearing.

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 Ms Deasy and Mrs Abdi.

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

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

- Ms 1: Band 7 Nurse and Team Leader on the Acute Intensive Care Unit of St Mary's Hospital
- Ms 2: Band 6 Nurse on the Adult Intensive Care Unit of St Mary's Hospital
- Ms 3: Senior Sister (Band 7) and Team Leader on Acute Intensive Care Unit of St Mary's Hospital
- Mr 1: Consultant Anaesthetist in the Acute Intensive Care Unit at St Mary's Hospital
- Mr 2: Anaesthetist Trainee Registrar at ST3 level in the Acute Intensive Care Unit at St Mary's Hospital

- Mr 3: Lead Technologist for the Directorate of Critical Care in St Mary's Hospital

The panel also heard evidence from you under oath.

Background

The charges arose whilst Mrs Abdi was employed as a registered nurse by Imperial College Healthcare NHS Trust ('The Trust'), working in the Acute Intensive Care Unit ('AICU').

The alleged incidents occurred on 28 September 2017, whilst Mrs Abdi was working on the AICU and caring for Patient A who required extubation and subsequent close monitoring following this procedure. This was the final day where Mrs Abdi was subject to supervised practice as part of a performance management program and was being supported by Ms 1 on this shift.

It is alleged that Mrs Abdi attempted to extubate Patient A on her own contrary to recognised practice on the AICU, following medical instruction to extubate. It is alleged that what she did was dangerous and was in contravention of the Foundation Critical Care Programme (FCCP) and of the AICU's Step 1 Competencies which all AICU nursing staff undertook.

Mrs Abdi was then allegedly found with Patient A alone again shortly after 14.00 on the same day and Patient A was in a collapsed state. Patient A was in a state of suspected respiratory arrest and required immediate intervention to prevent further deterioration. It is alleged that Mrs Abdi failed to respond by not pulling the crash bell or providing oxygen or bagging in a timely manner. It is further alleged that Mrs Abdi had administered a Propofol (a strong anaesthetic drug) bolus (i.e. a single extra dose of intravenous medication) via an infusion pump immediately prior to Patient A's sudden deterioration. It is alleged that

this was contrary to the principles taught in the FCCP and was contraindicated in the Propofol prescription which stated, *"for intubated patients only"*.

It is also alleged that Mrs Abdi modified Patient A's records namely Patient A's Propofol administration records in terms of the rate and volume of infusion and the syringe driver event log ('the event log') to cover up the cumulative volume of Propofol that was administered.

It is alleged that Mrs Abdi's actions at charges 5a, 5b and 6 were dishonest.

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 Mrs Abdi.

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

Charge 1a

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*
>
> *1) At around 13:15, extubated Patient A outside the scope of your competence, in that you carried out the extubation procedure;*
>
> *a) Alone."*

This charge is found proved.

In reaching this decision, the panel took into account the live and documentary evidence from Ms 1, Ms 2, and Mr 1.

The panel heard evidence from both Ms 1 and Mr 2 who were consistent in their evidence that they had found Mrs Abdi removing Patient A's endotracheal ('ET') tube in the room where Mrs Abdi was alone, without assistance from another experienced member of staff.

The panel heard evidence from Mrs Abdi. She stated that she was in the room alone after Mr 2 had left without her knowledge. However, the panel determined that Mrs Abdi's oral evidence was not consistent with the contemporaneous documentation from the local investigation when she explained she called Ms 1 and Ms 2 into the room where Mrs Abdi completed the procedure together.

The panel also heard evidence from Mr 1 about the manner in which an extubation is carried out and mentioned that it is typically *"done with two people"*. Ms 1 and Ms 2 both highlighted in evidence that this procedure should be carried out by two people. Ms 3 told the panel that extubation is always a two-nurse procedure and at all her time at the AICU, she has never witnessed or heard of another nurse attempting to extubate on their own.

On the basis of the evidence before it and on the balance of probability, the panel preferred the consistent evidence of the NMC witnesses to your accounts. The panel therefore found this charge proved.

Charge 1b

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*
>
> *1) At around 13:15, extubated Patient A outside the scope of your competence, in that you carried out the extubation procedure;*
>
> *b) Whilst Patient A was still drowsy/sedated"*

This charge is NOT found proved.

Ms Deasy had submitted that there is insufficient to support this charge and invited the panel not to make any findings on this charge.

The panel determined that conflicting evidence has been provided in that two witnesses, Ms 2 and Mr 2, gave evidence that Patient A was alert or awake, and Ms 1 gave evidence that Patient A was drowsy.

On the balance of probabilities, the panel found this charge not proved.

Charge 1c

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*
>
> *1) At around 13:15, extubated Patient A outside the scope of your competence, in that you carried out the extubation procedure;*
>
> *c) Whilst Patient A had score of -1 on the Richmond Agitation-Sedation Scale"*

This charge is NOT found proved.

Ms Deasy had submitted that there was insufficient evidence to support this charge and invited the panel not to make any findings on this charge.

The panel determined that there was conflicting evidence with regards to the charge in particular the interpretation of the Richmond Agitation Sedation ('RAS') scale score.

The panel did NOT find this charge proved.

Charge 1d

"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;

1) At around 13:15, extubated Patient A outside the scope of your competence, in that you carried out the extubation procedure;

d) Without securing the Anchor Fast Straps to Patient A's face"

This charge is NOT found proved.

The panel determined that there is no evidence before it to support the charge. The word *"securing"* as set out in the charge appears to contradict the evidence the panel heard regarding the steps necessary to remove an ET tube.

The panel did NOT find this charge proved.

Charge 1e

"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;

1) At around 13:15, extubated Patient A outside the scope of your competence, in that you carried out the extubation procedure;

(e) Without securing/removing Patient A's Endotracheal Tube"

This charge is found proved.

In reaching this decision, the panel took into account the live and documentary evidence from Ms 1, Ms 2, Mr 1, and Mr 2.

The panel considered the extubation process that was described by Mr 1. It noted that Patient A would be regarded as being extubated by the partial removal of the ET tube.

However, the panel heard from Mr 1, who gave evidence supporting the 'removing' element of the charge. He described the steps necessary to safely remove an ET tube *"in one smooth motion"*. Mr 2's evidence supports this.

Ms 2 stated she entered Patient A's room and found him *"coughing and gagging with the tube half-hanging out of his mouth"*. Ms 1 described seeing Patient A *"gagging, distressed with the tube half out…"*. Both witnesses described seeing you standing reassuring Patient A at this point.

The panel was of the view that the evidence before it did not support the 'securing' element of the charge. The panel noted that Mrs Abdi provided contradictory accounts around this event. The panel preferred the consistent account of the NMC witnesses.

The panel found this charge proved.

Charge 2a

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*
>
> *At around 14:00/14:30 did not escalate care for Patient A whilst they were unresponsive/deteriorating, in that you;*
>
> *a) Did not pull the crash bell in a timely manner"*

This charge is proved.

In reaching this decision, the panel took into account the live and documentary evidence before it, including the oral evidence from Ms 1 and Mrs Abdi.

The panel took into account that Ms 1 was alerted by Mrs Abdi shouting Patient A's name, ran into the room, immediately assessed Patient A's state as being unresponsive and required resuscitation. Ms 1 considered that Mrs Abdi should have recognised this and instructed her to pull the emergency crash bell.

The panel also noted that Mrs Abdi's oral evidence was confused, but that she accepted that she should have pulled the crash bell but did not do it.

The panel found this charge proved.

Charge 2b

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*
>
> *At around 14:00/14:30 did not escalate care for Patient A whilst they were unresponsive/deteriorating, in that you;*
>
> *(b) Did not provide oxygen/conduct re-breathing/bagging in a timely manner"*

This charge is proved.

In reaching this decision, the panel took into account the live and documentary evidence before it, including the witness statement from Ms 1 and Mrs Abdi's oral evidence.

During her oral evidence, Mrs Abdi told the panel that she were assessing the patient, but later, in cross-examination, accepted that she *"panicked",* and she should have given

Patient A oxygen. The panel noted that Ms 1 came in, immediately took control of the situation, started oxygen and initiated bagging.

On the basis of the evidence before it, the panel preferred the consistent account of Ms 1 over Mrs Abdi's inconsistent account.

The panel found this charge proved on the balance of probabilities.

Charge 2c

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*
>
> *At around 14:00/14:30 did not escalate care for Patient A whilst they were unresponsive/deteriorating, in that you;*
>
> *(c) Had prematurely removed Patient A's Anchor Fast Straps"*

This charge is NOT proved.

In reaching this decision, the panel were of the view that the NMC did not provide any submissions to support this charge in relation to Patient A's collapse. It noted that Ms Deasy conceded that there is no evidence to support this charge.

The panel therefore found this charge was NOT proved.

Charge 2d

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*

At around 14:00/14:30 did not escalate care for Patient A whilst they were unresponsive/deteriorating, in that you;

(d) Had prematurely deflated Patient A's Endotracheal Tube cuff"

This charge is NOT proved.

In reaching this decision, the panel were of the view that the NMC did not provide any submissions to support this charge in relation to Patient A's collapse. It noted that Ms Deasy conceded that there is no evidence to support this charge.

The panel therefore found this charge was NOT proved.

Charge 3

"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;

Administered Propofol to Patient A after extubation/whilst they were not ventilated."

This charge is proved.

In reaching this decision, the panel took into account the evidence from Ms 1, who was concerned a bolus of Propofol had been administered to Patient A when he was not ventilated, due to his sudden deterioration. She explained she had seen similar incidents when patients had been given a bolus dose of Propofol in the past. She described securing the syringe driver which delivered the Propofol later in the shift to allow for technical analysis of its recordings, prior to reporting this concern. The panel also took into account the investigation documentation compiled by Ms 3 and of Mr 3's evidence in relation to the syringe driver's functions and the spreadsheet he produced charting the manufacturer's log, i.e. the event log. It heard that the event log can only be accessed by medical technicians or the manufacturer to interrogate the machine events. Mr 3 also gave

evidence that the event log is not visible to standard users of the equipment and cannot be deleted or tampered with.

The panel also heard from Mr 3 that the event log showed that a 3.1ml bolus of an unspecified intravenous fluid was administered via the syringe driver at 14.06. The panel had sight of the copy of the event log exhibited. Mr 3 explained that the only way the bolus could be delivered was by continuously pressing a button on the syringe driver and that the bolus had been delivered over a period of 15 seconds.

Both Ms 1 and Mr 3 described Propofol as being of a distinctive opaque white milky appearance. Ms 1 described that the syringe driver containing what she recognised as Propofol remained connected to Patient A at the time of their deterioration. This was despite the Propofol having been discontinued prior to Patient A's extubation.

The panel heard evidence from you that you had been the only nurse in the room, had been preparing other medication there, and Patient A had been restless, when they collapsed. Ms 1 confirmed she had seen no-one else enter Patient As room around this time. No single underlying cause was identified in the medical investigations carried out following their suspected respiratory arrest.

Mr 1 said in his statement that Patient A had numerous complications and could have collapsed for a number of reasons.

This statement was made at a time where Mr 1 was under the mistaken impression that Patient A could have been given 3.1mg of Propofol. He revised his opinion in his oral evidence which was given after he had been made aware the bolus recorded by the event log was 3.1 mls – amounting to 62mg of Propofol. He considered this dose would be a strongly sedative dose of Propofol in Patient A's case. He described Propofol as being a respiratory depressant drug that could induce respiratory arrest, having effect within 40-90 seconds following its administration, and that a volume as high as 3.1mls would not be given in one bolus to sedate any patient.

The panel noted that Mrs Abdi consistently deny administering the medication, but it considered the weight of the evidence suggesting that Patient A received a bolus of Propofol whilst Mrs Abdi was the only clinician in the room. Due to the overwhelming weight of evidence surrounding this charge, the panel determined that on the balance of probabilities, Mrs Abdi had administered Propofol to Patient A after extubation, when they were not ventilated.

Therefore, the panel concluded that this charge is proved.

Charge 4

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;*
>
> *Administered propofol to Patient A without authorisation/supervision."*

This charge is proved.

The panel took into account the live and documentary evidence before it, including the evidence of Ms 1 and Ms 3. It also took into account that Mrs Abdi denied this charge.

The panel was of the view that there is no evidence to suggest that Mrs Abdi administered medication with supervision or that she was authorised to do so. It noted that Mrs Abdi accepted that she was alone at the time of Patient A's collapse.

The panel considered that Mrs Abdi was only authorised to administer 20mg of Propofol at five-minute intervals as needed, whilst Patient A was intubated as set out in Patient A's electronic prescription. However, Patient A was extubated at the time of their deterioration, therefore Mrs Abdi was no longer authorised to administer Propofol by prescription.

The panel took into account that Ms 3 exhibited a flow chart from a FCCP session stipulating a sedation bolus (ie. Propofol) should only be given by medical staff, as opposed to nurses, in circumstances when the airway was not protected. The panel found that this evidence was supported by an email confirming Mrs Abdi's attendance at this session.

The panel therefore found, on the balance of probabilities, this charge PROVED.

Charge 5a

> *"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017; At around 16:48 retrospectively/inaccurately modified Patient A's ICIP records in that you;*
>
> a) *Retrospectively modified the cumulative volume of propofol administered to Patient A from 5ml/hr to 2ml/hr."*

This charge is found NOT proved.

The panel took into consideration documentary evidence.

The panel is of the view that there is a fundamental difficulty with this charge; it noted that the charge did not make technical sense. It considered the charge is contradictory as it refers to two separate readings; on one hand, the cumulative (total) volume of Propofol administered and on the other hand, the rate at which it has been delivered (5ml/hr to 2ml/hr).

The panel finds this charge not proved.

Charge 5b

"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017; At around 16:48 retrospectively/inaccurately modified Patient A's ICIP records in that you;

b) Retrospectively modified the rate of delivery of Propofol to Patient A"

This charge is found proved.

The panel took into consideration the live and documentary evidence before it, including Mrs Abdi's oral evidence and the evidence of Ms 3.

The panel took into account that the documentary evidence from Ms 3 demonstrated that there had been modifications to the 12.00 and 13.00 records of the Propofol delivery. These modifications were made later that day at 16.48, to show a reduced rate from 5ml/hr to 2ml/hr by someone using Mrs Abdi's password and log-in.

The panel also took into account the local interview on 19 Jan 2022, in which Mrs Abdi admitted that she did make the Propofol changes but were unsure why as [PRIVATE]. The panel heard that Mrs Abdi explained that she did not remember making any of these changes, that she was *"panicking"* and *"distressed"*, and that she left her log-in open at times, which was not her usual practice.

The panel preferred the contemporaneous documentation and the consistent evidence of the NMC witnesses. The panel considered, on the evidence before it and on the balance of probabilities, that it is implausible that someone else would repeatedly re-enter and modify Patient A's records using Mrs Abdi's log-in, as shown in the records at 16.12 and 16.48.

The panel finds this charge proved.

Charge 6

"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;

Did not record that a bolus of 3.1ml at a rate of 900ml/h had been administered to Patient A at around 14:06."

This charge is found proved.

The panel took into the account the live and documentary evidence before it, including the evidence of Mr 3 and Ms 3.

The panel considered the event log which Mr 3 explained showed a detailed record of the pump's functions over the day. In evidence, Mr 3 explained that this information was not visible to the nursing staff and that this information cannot be erased. The panel took into account that the data from the event log shows that a 3.1ml bolus was administered at 14:06.

The panel considered Ms 3's evidence which concluded that Patient A's record shows no entry of a bolus being given to Patient A. The panel noted that the event log demonstrated that the cumulative total administered by the syringe driver matched the original volume of Propofol infusion prior to modification. This total would include a 3.1ml bolus within 0.4ml. The panel noted that from the event log before it, it could not identify which substance had been given or who had administered the bolus.

Taking account of all the evidence before it, the panel found, on the balance of probabilities, this charge PROVED.

Charge 7

"That you, a registered nurse, whilst employed on the Acute Intensive Care Unit at St Mary's Hospital London, on 28 September 2017;

Your actions in charge 5 a), 5 b) & 6 were dishonest as you sought to misrepresent the dose/volume/delivery rate of propofol administered to patient A."

This charge is found proved.

In reaching this decision, the panel took into account the live and documentary evidence before it, including the evidence of Ms 3 and Mrs Abdi's oral evidence.

The panel was of the view that overall, Mrs Abdi's oral evidence was inconsistent and contradictory. The panel found no evidence of anyone else altering or having motive in altering the records. There is no evidence that technical data produced was unreliable.

The panel took each charge in turn to decide whether your actions were dishonest.

Charge 5a

As the panel found this charge not proved, it cannot be considered within this charge.

Charge 5b

The panel took into account the live and documentary evidence before it.

The panel heard that Ms 3 highlighted the modifications made using Mrs Abdi's log-in several hours after the events ('the modifications'), alongside the absence of any explanation from Mrs Abdi led her to conclude that this was done to *"cover up practice which she knew to be wrong"*.

The panel also heard that Mrs Abdi was under pressure as she was under a Personal Development Plan (PDP). Mrs Abdi acknowledged that she *"panicked",* and she was in an emotional state.

The panel determined that the modifications were made deliberately in an attempt to cover up the higher hourly rate of Propofol which was delivered. It determined that Mrs Abdi attempted to cover up her poor practice. Accordingly, the panel considered Mrs Abdi was

aware that her actions under charge 5b were dishonest and that this conduct would also be considered dishonest by the objective standards of ordinary, decent people.

The panel find your actions in relation to charge 5b were dishonest.

Charge 6

The panel took into account the live and documentary evidence before it, including the evidence of Ms 3 and Mrs Abdi's oral evidence.

The panel concluded that Mrs Abdi's omission giving rise to charge 6 was dishonest.

In reaching its decision, the panel determined that Mrs Abdi's denial and failure to document her administration of a 3.1ml bolus of Propofol to Patient A, demonstrates an attempt to cover her poor practice.

Accordingly, the panel considered Mrs Abdi was aware that her failure to record the bolus as set out in charge 6 was dishonest. The panel found that this conduct would also be considered dishonest by the objective standards of ordinary, decent people.

The panel found that Mrs Abdi's failure in relation to charge 6 was dishonest.

Charge 7 (continued)

Therefore, the panel determined that this charge is found proved in respect of charges 5b and 6.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Abdi was not in attendance and that the Notice of Hearing letter had been sent to Mrs Abdi's registered address by recorded delivery sent first class on 13 February 2023.

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

The panel accepted the advice of the legal assessor.
The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was resuming virtually, including instructions on how to join and, amongst other things, information about Mrs Abdi's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Abdi 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 Mrs Abdi

The panel next considered whether it should proceed in the absence of Mrs Abdi. It had regard to Rule 21 and heard the submissions of Ms Deasy who invited the panel to continue in the absence of Mrs Abdi. She submitted that Mrs Abdi had voluntarily absented herself.

Ms Deasy submitted that there had been no engagement at all by Mrs Abdi with the NMC in relation to these resuming proceedings. She informed the panel that the NMC case officer had tried to contact Mrs Abdi by telephone and email but received no response, and that the NMC case officer again tried to telephone Mrs Abdi this morning, but the telephone call went to voicemail. She submitted that although there has been no specific response from Mrs Abdi, the lack of response suggests that Mrs Abdi does not intend to join this hearing. She submitted that, as a consequence, there was no reason to believe that an adjournment would secure her 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'*.

The panel has decided to proceed in the absence of Mrs Abdi. In reaching this decision, the panel has considered the submissions of Ms Deasy and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* (No.2) [2002] UKHL 5 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 Mrs Abdi;
- Mrs Abdi has not engaged with the NMC regarding the resuming proceedings and has not responded to contact attempts made to her about this resuming hearing;
- There have been instances in the first instalment of this hearing where Mrs Abdi absented herself,
- The charges relate to events that occurred in 2017; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Abdi in proceeding in her absence, but to mitigate this disadvantage, the evidence upon which the NMC relies has been sent to Mrs Abdi at her registered address. Furthermore, the limited disadvantage is the consequence of Mrs Abdi's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Abdi. The panel drew no adverse inference from Mrs Abdi's absence in its findings of fact.

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 Mrs Abdi's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Abdi'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.'*

Ms Deasy 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.

Ms Deasy identified the specific, relevant sections of the Code where Mrs Abdi's actions amounted to misconduct. She submitted that the conduct found proven involved serious departures from the standards set down in the Code.
In relation to seriousness, Ms Deasy submitted that the panel should have regard to the following factors in relation to charges 1 and 2:

a. Mrs Abdi's frame of mind; [PRIVATE] as she was on her last day of supervision, and that she did not advise any colleagues of this or seek support.

b. Mrs Abdi undertook the procedure of extubation alone contrary to the FCCP and of the AICU's Step 1 Competencies. She submitted that Mrs Abdi had previously received training on this procedure and was being supported by senior staff members throughout her shift, and therefore her actions did not stem from a lack of knowledge or inability to practice.

c. Mrs Abdi recognised in evidence that this was *"not the right thing to do"* and was *"not correct"*. She submitted that this was a deliberate action outside of the scope of her competence and therefore that she deliberately chose to take an unreasonable risk with Patient A's safety.

d. The action of undertaking the extubation alone placed Patient A at risk and in visible physical distress. She noted that no ongoing serious harm was caused to Patient A.

e. Mrs Abdi's description on this incident as *"awkward and embarrassing…for the patient and the Trust"* seemingly failed to recognise the risk posed to Patient A by her actions.

f. Mrs Abdi failed to provide an accurate, detailed and timely account of her interaction with Patient A following the extubation process.

g. Mrs Abdi failed to accurately identify, observe or assess obvious signs of worsening physical health of Patient A in that Patient A was unresponsive and required resuscitation.

h. Mrs Abdi failed to make a timely referral to another practitioner when Patient A became unresponsive and action was required to be taken. She submitted that in this case, instead of pressing the crash bell to alert other staff on the ward of respiratory emergency and beginning the bagging procedure, Mrs Abdi touched and rubbed his chest, whilst calling his name twice.

i. Mrs Abdi recognised that this was not the best practice, and that the deterioration should have been escalated more quickly.

j. Mrs Abdi's explanation that this was a result of panic and lack of experience, and

k. Mrs Abdi's actions, [PRIVATE], were avoidable in the circumstances and placed Patient A at unwarranted risk of harm on both occasions.

In relation to charges 3 and 4, Ms Deasy submitted that:

a. The Registrant's actions were directly contrary to the principles taught in the FCCP and the propofol prescription which stated, *"for intubated patients only"*. By virtue of the panel's findings, this was a deliberate action outside the scope of her competence/authority and posed an unreasonable risk to Patient A.

b. In particular, the fact the Registrant had received specific training on the protocol for the administration of sedation from the Trust which included the requirement for proper authorisation.

c. The action of administering the propofol after extubation placed Patient A at risk of serious harm, including loss of consciousness and potential respiratory emergency.

d. Around an hour after the administration of the propofol Patient A did in fact experience a respiratory emergency. Again, it is noted that there was no ongoing serious harm caused to Patient A.

In relation to charges 5, 6 and 7, Ms Deasy submitted that:

a. Findings of dishonesty are incompatible with the code and serious misconduct is readily found.

b. The retrospective modification of the rate of delivery of propofol to Patient A and the lack of record that a bolus of propofol had been administered was done to conceal Mrs Abdi's earlier wrongdoing.

c. The effect of the amendment/lack of recording was done to fundamentally change the record of care for Patient A.

d. The amendment/lack of recording promoted a significant risk in the care of Patient A as it prevented others providing subsequent treatment to Patient A from making informed decisions as to their care. This is of particular importance on an ICU where patients themselves are often not in a position to communicate.

e. The Registrant provided conflicting evidence under oath, compared to that at local level: initially accepting she had made the amendments due to [PRIVATE], and under oath, stating that she could not remember doing so.

f. The Registrant alluded to the possibility others accessing her 'login' details to make amendments unbeknownst to her, suggesting colleagues had acted contrary to the Code.

Submissions on impairment

Ms Deasy 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).

Ms Deasy submitted Mrs Abdi has not participated in the second instalment of the proceedings and that therefore the panel does not have the benefit of direct evidence regarding her insight or remediation. She informed the panel that Mrs Abdi has not been subject to an interim suspension order as it appears that she has chosen not to work within a clinical care setting since her dismissal from the Trust in 2017. She invited the panel to consider whether there have been opportunities for Mrs Abdi to undertake remediation in a clinical or care setting as well as through her own personal education or training in the last five years.

Ms Deasy submitted that Mrs Abdi has demonstrated limited engagement with the NMC throughout the proceedings. In respect of charges 1 and 2, she submitted that whilst Mrs Abdi has made some apologies for *"the situation"* in writing and in evidence, there appears to have been limited acceptance of responsibility for her actions. She stated that Mrs Abdi pointed to a lack of support and inexperience as contributing to her actions. She submitted that this appears entirely contrary to the evidence, as for example: Mrs Abdi's failure to complete Immediate Life Support Training resulted in her being placed on a PDP, including during this shift. Mrs Abdi's training records suggest all other aspects of training had been completed satisfactorily. Ms Deasy submitted that the panel may consider that this is an indication of attitudinal issues and a failure to 'open up'. She submitted that Mrs Abdi has provided little evidence of insight into her actions and no evidence of actions taken to address her misconduct.

With regard to charges 3, 4, 5, 6 and 7, Ms Deasy submitted that Mrs Abdi has not accepted the conduct within these charges, and therefore, has not demonstrated any reflection, insight or remorse. She submitted that there is no evidence of actions taken to address the conduct, including the elements of dishonesty. She submitted that significant remediation is required to address issues of dishonesty and integrity sufficiently to prevent any further risks within Mrs Abdi's practice.

Overall, Ms Deasy submitted that, in light of Mrs Abdi's lack of insight and remediation, there is a real risk of repetition which poses a real risk to patients and service users. She submitted that, despite the significant period of time that has passed since the events giving rise to the charges arose, Mrs Abdi's fitness to practice is impaired on the grounds of public protection and in the wider public interest. She submitted that there is a clear risk, especially given the dishonesty charges, that public confidence would be undermined if a finding of impairment were not made.

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

> *"**1. Treat people as individuals and uphold their dignity.***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

10. Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice.

It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

13. Recognise and work within the limits of your competence.

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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

18. Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations.

To achieve this, you must:

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving…

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…"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Abdi's failures under the charges found proved together with the dishonesty elements found proved, amount to misconduct.

The panel found that these charges, as found proved, amount to serious clinical failings. It observed that the charges found proved demonstrate Mrs Abdi's repeated failures on that day, despite being supervised and help being available, placed Patient A, a vulnerable patient, at a real and significant risk of harm. It observed that Mrs Abdi's failures, particularly under charges 3 and 4 were reckless. With regard to charge 7 found proved in respect of charges 5b and 6, the panel concluded that Mrs Abdi's dishonesty fell far below the standards expected of a registered nurse and amounts to serious breach of the fundamental tenets of the profession.

The panel therefore found that Mrs Abdi's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act

with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the 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) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel finds that Patient A was put at risk of harm as a result of Mrs Abdi's misconduct. The panel was of the view that Mrs Abdi's misconduct had 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 dishonesty extremely serious. The panel found all four limbs of the *Grant* test engaged in this case.

Regarding insight, the panel considered that Mrs Abdi had demonstrated some insight in that she accepted aspects in relation to her clinical failings and has apologised to the Trust and to the NMC. However, the panel found that Mrs Abdi's insight is limited. The panel has no evidence before it of Mrs Abdi's reflection on the dishonesty elements found in this case. It noted that Mrs Abdi had provided the panel with testimonials and patient feedback forms.

Whilst the panel took into account that Mrs Abdi had previously engaged with the NMC and partially participated in the hearings process. It noted that Mrs Abdi has now stopped engaging with the process and has not provided any further evidence of relevant learning or reflection. The panel determined that there was evidence before it that Mrs Abdi has been working in a nursing capacity following the incident in 2017. However, it noted that it had no evidence before it regarding any steps which Mrs Abdi may have taken to address the concerns or strengthen her practice. Accordingly, the panel concluded that there is a real risk of repetition. The panel determined 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 in light of the dishonesty found proven. It concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case.

Having regard to all of the above, the panel determined that Mrs Abdi's fitness to practise is currently impaired.

Sanction

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

Submissions on sanction

Ms Deasy informed the panel that in the Notice of Hearing dated 30 August 2022, the NMC had advised Mrs Abdi that it would seek the imposition of a striking-off order if the panel found Mrs Abdi's fitness to practise currently impaired.

In Ms Deasy's submissions, she took the panel through what the NMC considered to be their main mitigating and aggravating factors in this case and set out the sanctions available to the panel. Ms Deasy highlighted the NMC guidance on dishonesty which sets out that 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 in someone's care.

The panel had the benefit of Mrs Abdi's attendance on some sections of the first instalment of the hearing including observing her giving evidence.

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

Decision and reasons on sanction

Having found Mrs Abdi'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:

- Dishonesty directly relating to patient care
- Breaching the professional duty of candour
- Placing a vulnerable patient at risk of harm
- Lack of insight into failings and lack of remediation
- Failure to deliver safe and fundamental care within the scope of practice of a registered nurse
- Failure to fully engage with the NMC

The panel also took into account the following mitigating features:

- Incidents occurred in a single shift
- Some insight and remorse in relation to charges 1 and 2
- Mrs Abdi felt under pressure on the day of the incidents as she was on the last day of supervision under the PDP

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

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

The panel next considered whether placing conditions of practice on Mrs Abdi's registration would be a sufficient and appropriate response. The panel is of the view that whilst conditions of practice may address the clinical failings found proved in this case, they could not address the dishonesty and attitudinal issues identified. The panel concluded that there are no workable or measurable conditions that could be formulated which would adequately address the dishonesty and seriousness of this case or 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:

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

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 Mrs Abdi's actions is fundamentally incompatible with Mrs Abdi remaining on the register.

Mrs Abdi had informed the panel that she had been working in a nursing capacity without any further concerns being raised since the incidents in 2017. The panel considered the patient feedback forms and the three testimonials which Mrs Abdi provided during her previous engagement with proceedings. However, the panel was able to put only limited weight on these as it was unclear as to whether the authors of the testimonials were aware of the charges which were brought against Mrs Abdi. However, the panel concluded that there is no evidence before it to suggest that her dishonesty had been addressed; Mrs Abdi provided no evidence of insight or remorse into her dishonesty, no relevant reflection or steps taken to strengthen her practice, if any. Having considered the NMC guidance on dishonesty, the panel found that elements of the misconduct in this case could be regarded as being the most serious kind of dishonesty.

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?*

Mrs Abdi's failings and in particular her dishonesty amounted to significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this

particular case demonstrate that Mrs Abdi's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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 Mrs Abdi's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, 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 will be confirmed to Mrs Abdi in writing.

Interim order

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

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

Submissions on interim order

The panel took account of the submissions made by Ms Deasy. She submitted that the sanction imposed by the panel cannot take effect until the end of the appeal period of 28 days from the date of the service of the determination to Mrs Abdi, or if an appeal is lodged by Mrs Abdi, until after that appeal is determined. She therefore invited the panel to impose an interim order for up to 18 months to cover any relevant appeal period.

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 to cover the determination of any appeal process which may be initiated by Mrs Abdi.

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

That concludes this determination.