Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 3 April – Friday 14 April 2023
Tuesday 30 May – Friday 2 June 2023
&
Monday 4 September – Wednesday 6 September 2023

Virtual Hearing

Name of Registrant:	**Mohamed Philip Bangura**
NMC PIN	97I7329E
Part(s) of the register:	Registered Nurse – RNMH Mental Health Nursing – March 2001
Relevant Location:	Bracknell Forest
Type of case:	Lack of competence/Misconduct
Panel members:	Caroline Rollitt (Chair, Lay member) Lorna Taylor (Registrant member) Tracy Stephenson (Lay member)
Legal Assessor:	Alain Gogarty
Hearings Coordinator:	Jasmin Sandhu (3 April 2023) Khadija Patwary (4 – 14 April 2023) (30 May – 2 June 2023) & (4 – 6 September 2023)
Nursing and Midwifery Council:	Represented by Matthew Kewley, Case Presenter
Mr Bangura:	Not present and unrepresented
Facts proved:	Charges 1), 3)a), 4), 6)a), 7)b), 8), 9), 10), 11), 12), 14)b), 16), 17), 18), 19)b), 21)a), 21)b), 22) and 23)

Facts not proved:	Charges 2), 3b), 5), 6b), 7)a), 13), 14)a), 15), 19)a) 20) and 21)c)
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 Bangura was not in attendance and that the Notice of Hearing had been sent to his registered email address by secure encrypted email on 6 March 2023.

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 Bangura's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

The panel accepted the advice of the legal assessor.

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

The panel next considered whether it should proceed in the absence of Mr Bangura. It had regard to Rule 21 and heard the submissions of Mr Kewley.

Mr Kewley took the panel through the chronology of the NMC's contact with Mr Bangura in respect of these proceedings. He informed the panel that Mr Bangura was first sent these hearing dates in October 2022. He was also sent these dates in the Notice of Hearing sent to him electronically on 6 March 2023.

Mr Kewley stated that there had been no engagement by Mr Bangura with the NMC until yesterday, 2 April 2023, at which point the NMC received an email from him stating the following:

> *'My apologies for not getting in touch with you. I will not be attending the hearing on Monday. I am happy for the panel to proceed in my absence.*
> *Thank for your assistance.'*

Mr Kewley submitted that it is clear from this email that Mr Bangura does not wish to attend this hearing and is content for it to proceed in his absence. Mr Kewley submitted that 13 NMC witnesses are due to attend this hearing and that not proceeding may inconvenience them and, for those involved in clinical practice, the clients who need their professional services. He further submitted that this is an aging case, and any further delay would have an impact on the witnesses' ability to recall events. Mr Kewley also submitted that there is a public interest in the expeditious disposal of this case.

In these circumstances, Mr Kewley invited the panel to continue in the absence of Mr Bangura.

The panel accepted the advice of the legal assessor who referred it to Rule 21 as follows:

> *'21. (1) This rule shall not apply to hearings at which the Committee is considering whether to make, revoke, confirm, vary or replace an interim order.*
> *(2) Where the registrant fails to attend and is not represented at the hearing, the Committee*
> *(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;*
> *(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or*
> *(c) may adjourn the hearing and issue directions.'*

The panel was reminded 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 was also referred to the cases of *Golden v Nursing and Midwifery Council* [2023] EWHC 619 (Admin) and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

The panel has decided to proceed in the absence of Mr Bangura. In reaching this decision, the panel has considered the submissions of Mr Kewley, the email from Mr Bangura dated 2 April 2023, 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* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- All reasonable efforts have been made by the NMC to engage Mr Bangura in these proceedings;
- Mr Bangura informed the NMC, by email on 2 April 2023 (yesterday), that he will not be attending this hearing and that he is content for the hearing to proceed in his absence;
- No application for an adjournment has been made by Mr Bangura and there is no reason to suppose that adjourning would secure his attendance at some future date;
- 13 witnesses are scheduled to attend this hearing to give live evidence and not proceeding may inconvenience those witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- These charges relate to events that allegedly occurred between 2017 – 2020 and any 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.

The panel noted that there may be some disadvantage to Mr Bangura in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC at this hearing 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 Bangura'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 and appropriate to proceed in the absence of Mr Bangura. The panel will draw no adverse inference from Mr Bangura's absence in its findings of fact.

Details of charge

That you a registered nurse, failed to demonstrate the standards of knowledge, skill and experience required to practise safely as Band 5 nurse between 12 June 2017 and 19 September 2020.

Whilst employed at West London Mental Health NHS Trust:

1) Between 12 June 2017 and 19 July 2017 did not produce a care plan for Patient 1. **(proved)**

2) On or before 13 April 2018: **(not proved in its entirety)**
   a) did not ensure an eyesight observation check was carried out for a period of one hour for unknown patients;
   b) did not complete an observation form for unknown patients.

3) On or before 2 May 2018:
   a) you gave a CPA report to patient 2 which contained an unknown patient's details. **(proved)**
   b) You produced a CPA report with repetitive content. **(not proved)**

4) On or before 20 July 2018 you had outstanding CPA reports for Patient D and / or Patient E. **(proved)**

5) On or before 17 August 2018 changes of behaviour and / or concerns with risk were not handed over to the multi-disciplinary team. **(not proved)**

6) On or around 7 September 2018:
   a) failed to evaluate and / or update care plans for unknown patients. **(proved)**
   b) Produced a tribunal report with: **(not proved in its entirety)**
      i) Incorrect content;
      ii) Grammar errors;
      iii) Punctuation errors.

7) On or around 8 October 2018:
   a) did not complete a CPA report for Patient D; **(not proved)**
   b) did not complete one or more care plans for an unknown patients. **(proved)**

8) Between 1 October 2018 to 31 October 2018 you recorded one primary nurse 1:1 session on RIO for Patient D. **(proved)**

9) On or before 5 November 2018 you did not provide a copy of a CPA report: **(proved in its entirety)**
   a) to Colleague A;
   b) to Patient D.

10) On or before 5 November 2018 you did not correctly evaluate a care plan for Patient D. **(proved)**

11) On 7th November 2018 you provided a negative view of Patient A during a CPA meeting. **(proved)**

12) On 7 November 2018 did not complete a physical health assessment for Patient F. **(proved)**

13) On or before 17 December 2018: **(not proved in its entirety)**
    a) did not implement a management plan.
    b) on one or more occasions did not record your interaction with unknown patients on RiO.
    c) did not produce the required standard of content for care plans.
    d) did not produce the required standard of content for written reports.

14) On or before 18 March 2019:
    a) did not complete one or more care plans for unknown patients; **(not proved)**
    b) did not record your 1:1 primary nurse sessions on RiO in a timely manner. **(proved)**

15) on or before 4 February 2020: **(not proved in its entirety)**
    a) on one or more occasions did not delegate roles;
    b) did not communicate clearly and / or concisely.

16) On 4 March 2020 you: **(proved in its entirety)**
    a) did not know where the second line emergency drugs were located.
    b) did not know how the second line emergency drugs were;
        i) Administered;
        ii) Conditions they were used for.
    c) You prepared and / or administered medication without checking the prescriptions against Patient 5 and / or Patient 6 consent forms.
    d) You did not identify the consent form when checking the prescription of Patient 7.

17) On one or more of the following dates you did not pass the Medicine Administration and / or Safe Storage Practice Standards Assessment: **(proved in its entirety)**
    a) 4 March 2020.
    b) 22 April 2020.

18) On or before 6 March 2020 failed to produce the required content for Patient G's CPA nursing report by: **(proved in its entirety)**
    a) Not recording they had yellow ground access;
    b) Including IR1's from 2 October 2018;
    c) Not recording they had their rights read to them under section 132 of the Mental Health Act on 24 January 2020.
    d) Did not record an incident that occurred 6 October 2019.

19) On one or more of the following dates did not correctly use the Z tracking technique to administer IM depot injections:
    a) 26 March 2020. **(not proved)**
    b) To Patient 9 on 24 April 2020. **(proved)**

20) On or before 26 March 2020 failed to produce the required content for Patient 10's CPA report by recording out of date information. **(not proved in its entirety)**

21) On 17 April 2020 you:
a) failed to call site management to organise extra staff for an escort of unknown patients to the patient shop; **(proved)**
b) Failed to make a list of unknown patients attending; **(proved)**
c) You did not know who should be allocated to escort unknown patients. **(not proved)**

Whilst employed at Berkshire Healthcare NHS Foundation Trust:

22) On 29 August 2020 you allowed Patient B to move around the ward without keeping them in your sight at all times. **(proved)**

23) On 17 September 2020 you: **(proved in its entirety)**
    a) instructed staff to open the place-of-safety door;
    b) allowed Patient C to leave the building;

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence and / or misconduct.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kewley to amend the charges. In relation to the initial stem of the charges, as well as charges 2), 3), 6), 7), 15), 18), and 21), Mr Kewley invited the panel to consider the following amendments:

*'That you a registered nurse, failed to demonstrate the standards of knowledge, skill and experience required to practise safely as Band 5 nurse between ~~21~~ **12** June 2017 and 19 September 2020.*

Whilst employed at West London Mental Health NHS Trust:

2) *On or before ~~20 September 2017~~ **13 April 2018:***
   a) *did not ensure an eyesight observation check was carried out for a period of one hour for unknown patients;*
   b) *did not complete an observation form for unknown patients.*

3) *On or before ~~20 September 2017~~ **2 May 2018**:*
   a) *you gave a CPA report to patient 2 which contained an unknown patient's details.*
   b) *You produced a CPA report with repetitive content.*

6) *On or ~~before~~ **around** 7 September 2018:*
   a) *failed to evaluate and / or update care plans for unknown patients.*
   b) *Produced a tribunal report with:*
      i) *Incorrect content;*
      ii) *Grammar errors;*
      iii) *Punctuation errors.*

7) *On or ~~before~~ **around** 8 October 2018:*
   a) *did not complete a CPA **report** for Patient D;*
   b) *did not complete one or more care plans for **an** unknown patient~~s~~.*

15) *on or before **4** ~~5th~~ February 2020:*
   a) *on one or more occasions did not delegate roles;*
   b) *did not communicate clearly and / or concisely.*

18) *On or before 6 March 2020 failed to produce the required content for Patient G**'s** CPA nursing report by:*
   a) *Not recording they had yellow ground access;*
   b) *Including IR1's from 2 October 2018;*
   c) *Not recording they had their rights read to them under section 132 **of the** Mental Health Act on ~~2019~~ **24 January 2020.***
   d) *Did not record an incident that occurred 6 October 2019.*

21) *~~Between 16 April 2020 and~~ **On** 17 April 2020 you:*
   a) *failed to call site management to organise extra staff for an escort of unknown patients to the patient shop;*
   b) *Failed to make a list of unknown patients attending;*
   c) *You did not know who should be allocated to escort unknown patients.'*

Mr Kewley submitted that the above amendments, as applied for, were to correct the typographical errors and incorrect dates contained in the original allegations. He submitted that there would be no prejudice caused to Mr Bangura by allowing these amendments.

Mr Kewley also referred the panel to charge 23, proposing the following amendment:

'23) On 17 September 2020 you:

a) instructed staff to open the place-of-safety door;

b) allowed Patient C to leave the building;

c) Did not call for assistance and/or use Prevention and Management of Violence and Aggression techniques to manage the situation with Patient C in the first instance;

d) Did not activate the Personal Infrared Transmitters alarm when Patient C first became verbally aggressive.'

Mr Kewley submitted that whilst this amendment constitutes an addition to the charges, this addition causes no prejudice to Mr Bangura. It was submitted by Mr Kewley that this amendment is merely a further particularisation of the incident alleged in charge 23. He submitted that the addition of these proposed sub-charges is borne out of the same evidence that Mr Bangura has received, and it does not increase the gravity of this case.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules as follows:

'28.(1) At any stage before making its findings of fact, in accordance with [rule 24(5) or (11)], the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) [or the Fitness to Practise] Committee, may amend

(a) the charge set out in the notice of hearing; or

(b) the facts set out in the charge, on which the allegation is based, unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'

With regard to the initial stem of the charges, as well as charges 2), 3), 6), 7), 15), 18), and 21), the panel was of the view that such amendments, as applied for, would cause no prejudice to Mr Bangura. It considered that these amendments have been proposed to correct typographical errors and incorrect dates which would provide further clarity and accuracy. The panel therefore decided to allow these amendments.

In relation to the proposed additions to Charge 23, the panel was of the view that this amendment would cause prejudice to Mr Bangura. The panel noted that these proposed additional sub-charges relate to the same incident as the existing charge. However, it also bore in mind that this amendment was proposed at a late stage and that Mr Bangura is not present at this hearing to voice a response to the application. Whilst Mr Bangura has indicated that he does not wish to attend this hearing and is content for the hearing to proceed in his absence, the panel noted that this was on the basis of the original charges and that he was not aware of any proposed additions. In these circumstances, the panel determined that it would not be fair to allow this amendment. As such, the application to amend Charge 23 is rejected.

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

Mr Kewley, on behalf of the NMC, made a request that parts of this hearing be held in private on the basis that proper exploration of Mr Bangura's case involves references made by several witnesses commenting on a period of unexplained sickness absence. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be references to a period of Mr Bangura's unexplained sickness absence, the panel determined to hold parts of the hearing in private in order to preserve the confidential nature of those matters. The panel was satisfied that these considerations justify that course, and that this outweighs any prejudice to the general principle of hearings being in public.

Background

The NMC received an initial referral regarding Mr Bangura's fitness to practise on 17 August 2020. The referral was made by the Nurse Consultant at West London Mental Health NHS Trust (the Trust). At the time of the concerns raised in that referral, Mr Bangura was working as a registered nurse with West London Trust.

Mr Bangura commenced employment with the Trust in 2001 and worked at Broadmoor Hospital, a high security mental health unit. He moved to work on Sandown Ward, at his own request, in March 2017. Concerns were raised about the quality of Mr Bangura's care plans by his manager, Colleague A, and he was placed on a Performance Improvement Plan on 21 June 2017. The concerns related to Mr Bangura's failure to write and maintain care plans to the required standard, grammatical errors, factually incorrect content and that his care plans were not recovery focused.

It is said that there were no improvements and Mr Bangura was progressed to the informal stage of the trust capability process. Initially this was informal with a three-month action plan to complete. At this stage, additional concerns were noted in relation to Mr Bangura's:

- Ability to write Care Plan Approach (CPA) reports;
- Ability to act as the Nurse in Charge (NIC);
- Communication;
- Care planning and evaluation; and
- Medicines management.

It is also alleged that Mr Bangura was not checking medication consent forms and had little knowledge of using the "*Z tracking technique*" for the correct administration of intramuscular medication.

Concerns were also raised about Mr Bangura's ability to formulate care plans and that he was copying and pasting care plans. It is alleged that Mr Bangura gave a patient a Care Plan Approach (CPA) report which contained patient sensitive information about another patient and included the wrong patient's name in a care plan. This led to an Information Governance investigation. It is further alleged that Mr Bangura provided handovers with insufficient information and lacked leadership as a NIC.

On 1 August 2018, Mr Bangura was moved to the formal stage of the capability process.

In November 2018, Mr Bangura was referred to the Practice Development Nurse/Matron to obtain support with his development, implementation and evaluation of care plans. It is alleged that Mr Bangura attended one of these sessions and then failed to engage with them further.

A capability hearing was held on 27 September 2019, at which Mr Bangura did attend. The panel at that hearing extended the capability process for a further six months. Mr Bangura was transferred to Sandhurst Ward, under the line management of clinical nurse manager, Witness 1. Mr Bangura was to complete an action plan, followed by a further assessment in six months, with reviews at one, three and six months.

Mr Bangura transferred to Sandhurst Ward on 21 October 2019. During the period of extended capability monitoring, Mr Bangura was allocated only one named patient. He was expected to plan, implement and evaluate their care plan, updating it at least every 28 days. It is said that, ordinarily, nurses at Broadmoor would have up to three named patients. To allow Mr Bangura to focus and demonstrate his capability, he only had one. A training plan was also developed.

Throughout the following six months, although there were improvements, it is said that Mr Bangura struggled to achieve the required standards for care planning and report writing. It is alleged his care plans did not reflect person centred care, contained little evidence of the patient concerned, were prescriptive and had no clarity of outcomes or structure. They also contained grammatical errors and factual inaccuracies.

It is alleged that concerns with Mr Bangura's abilities as NIC and medications management, for example his inability to carry out or to understand the "*Z tracking technique"*, continued. The Z track injection is a well established technique, used to ensure the optimal dose of certain medication is administered and is a basic skill, taught on pre-registration nursing courses. Concerns were also reported with his medicines administration skills and basic medicine knowledge. These were highlighted when undergoing medicines management assessment.

On 2 July 2020, a final capability panel hearing was held and focussed on five areas of concern, as follows:

- Report writing
- Role of the nurse in charge
- Communication
- Care planning and evaluation
- Medicines management.

Mr Bangura submitted his resignation from the Trust on 9 July 2020.

Following his resignation from the Trust, Mr Bangura completed nine shifts as a bank nurse for Berkshire Health between 26 August 2020 and 22 September 2020.

A further referral was made about Mr Bangura's fitness to practise on 30 October 2020 by Berkshire Healthcare NHS Foundation Trust (Berkshire Health).

Whilst working at Berkshire Health, it is alleged that on 29 August 2020 Mr Bangura allowed Patient B to move around the ward without keeping them in his sight at all times. It is also alleged that on 17 September 2020, Mr Bangura instructed staff to open the place-of-safety door and allowed Patient C to leave the building.

A disciplinary hearing took place on 9 February 2021 in relation to these incidents at Berkshire Health. Mr Bangura was not in attendance.

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 Kewley on behalf of the NMC.

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

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 A: Clinical Nurse Manager at the Trust at the time of the allegations;

- Witness 1: Clinical Nurse Manager at the Trust at the time of the allegations;

- Witness 2: Medicines Management Compliance Nurse at the Trust at the time of the allegations;
- Witness 3: Service Director at the Trust at the time of the allegations;
- Witness 4: Consultant Forensic Psychiatrist at the Trust at the time of the allegations;
- Witness 5: Social Worker at the Trust at the time of the allegations;
- Witness 6: Clinical Nurse Team Leader at the Trust at the time of the allegations;
- Witness 7: Practice Development Nurse/Matron at the Trust at the time of the allegations;
- Witness 8: Support Worker at Berkshire Health at the time of the allegations;
- Witness 9: Support Worker at Berkshire Health at the time of the allegations;
- Witness 10: POS Manager at Berkshire Health at the time of the allegations;

- Witness 11: Practice Development Nurse at the Trust at the time of the allegations;

- Witness 12: Deputy Ward Manager at Berkshire Health 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 separately and made the following findings.

Charge 1)

1) Between 12 June 2017 and 19 July 2017 did not produce a care plan for Patient 1.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a meeting letter dated 24 July 2017.

The panel considered Colleague A's witness statement in which she stated that "*On 24 July 2017, a patient did not have a care plan in place when Mo was the Primary Nurse for this patient. At the Trust we look at the 6 areas – Risk to Self, Risk to Others, Mental Health & Wellbeing, Physical Health, Medication Management and Interpersonal Relationship. We look at these main areas along with the patient views to formulate the care plan.*"

The panel heard that a primary nurse was expected to formulate an individual care plan for the newly admitted, allocated patient within a week of admission.
The panel had regard to the meeting letter dated 24 July 2017 relating to a meeting between Mr Bangura and Colleague A on 18 July 2017, in which College A stated that "*You do not currently have care plans in place for your Primary Patient of which has caused great concern. This patient was admitted on 18 May 2017; the patients within our services are entitled to and deserve to receive a high standard of individualised care and treatment, therefore, this is unacceptable.*" The panel noted that a personal improvement plan (PIP) was implemented on 12 June 2017 which Mr Bangura had signed and confirmed that he understood the care plans. The panel determined on the balance of probabilities that between 12 June 2017 and 19 July 2017, Mr Bangura did not produce a care plan for Patient 1.

Therefore, the panel finds this charge 1) proved.

Charge 2)a)

2) On or before 13 April 2018:
    a) did not ensure an eyesight observation check was carried out for a period of one hour for unknown patients;

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a meeting letter with action plan review dated 20 April 2018.

The panel noted that in respect of this charge, Colleague A in her oral evidence was unable to remember the dates or remember who the staff member was that told her about the observations. This is confirmed in Colleague A's witness statement in which she stated that "*During one shift that Mo was NIC it became evident that he failed to ensure that an eyesight observation check for a period of one hour had taken place on a shift..*" The panel also had sight of the action plan which states "*Eyesight observation – Staff reported that this was not undertaken…*" It noted that Colleague A's recollection of this incident was vague.

The panel was not satisfied that on the balance of probabilities Mr Bangura did not ensure an eyesight observation check was carried out for a period of one hour for unknown patients.

Therefore, the panel finds this charge 2)a) not proved.

Charge 2)b)

2) On or before 13 April 2018:
   b) did not complete an observation form for unknown patients.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a meeting letter with action plan review dated 20 April 2018.

The panel considered Colleague A's witness statement in which she stated that "*he failed to ensure that an eyesight observation check for a period of one hour had taken place on a shift and the observation form was not completed*." It noted that Colleague A stated that the nurse in charge at the time who was Mr Bangura was responsible for an eyesight observation check being undertaken but not for completing an observation form.

The panel further noted that Colleague A in her oral evidence confirmed Mr Bangura was not personally responsible for completing the observation form. It was of the view that this made it unclear who was responsible for completing the observation form.

The panel was not satisfied that on the balance of probabilities Mr Bangura did not complete an observation form for unknown patients.

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

Charge 3)a)

3) On or before 2 May 2018:
   a) you gave a CPA report to patient 2 which contained an unknown patient's details.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a meeting letter dated 21 May 2018 and the capability policy/report.

The panel considered Colleague A's witness statement in which she stated that "*…there was an incident where Mo completed a CPA report for a primary patient and gave it to the patient. The report was then handed back to the staff by the primary patient because it contained patient information which related to another patient. [PRIVATE]. Mo said that he had used a template which he copied and pasted from a previous report. I had to write to both the patients to apologise and explain about this incident and inform Information Governance...*"

The panel determined that on the balance of probabilities Mr Bangura gave a CPA report to Patient 2 which contained an unknown patient's details.

Therefore, the panel finds this charge 3)a) proved.

Charge 3)b)

3) On or before 2 May 2018:
    b) You produced a CPA report with repetitive content.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's witness statement and oral evidence.

Colleague A in her oral evidence stated that "*there was a copy and paste twice or something…*" the panel was of the view that this was as much detail as it could derive in relation to this charge. The panel did not have sight of this report and Colleague A's recollection in her oral evidence was too vague in relation to the detail. Therefore, the panel was not satisfied that on the balance of probabilities Mr Bangura produced a CPA report with repetitive content.

In light of the above, the panel finds this charge 3)b) not proved.

Charge 4)

4) On or before 20 July 2018 you had outstanding CPA reports for Patient D and / or Patient E.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a meeting letter dated 20 July 2018.

The panel considered Colleague A's witness statement in which she stated that "*On 20 July 2018, there were two outstanding CPA reports that Mo had to do which were overdue. The patient should receive their report 2 weeks before their CPA meeting in order for them to discuss with the Primary Nurse and resolve any issues or concerns, but this was not met.*"

Colleague A in her letter to Mr Bangura dated 20 July 2018 stated that "*…I am sure that you can appreciate that the reports are extremely overdue. Moreover, it is very important that our patients receive their CPA reports 2 weeks prior to submission to enable them to prepare for their meeting and to discuss any concerns that they may have regarding their care pathway*."

The panel determined that on the balance of probabilities, on or before 20 July 2018, Mr Bangura had outstanding CPA reports for Patient D and / or Patient E.

Therefore, the panel finds this charge 4) proved.

Charge 5)

5) On or before 17 August 2018 changes of behaviour and / or concerns with risk were not handed over to the multi-disciplinary team.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a meeting letter dated 17 August 2018.

The panel noted that Colleague A's evidence in relation to this charge was vague given the passage of time. Colleague A was unable to say what information had not been handed over or to whom.
It further noted that the meeting letter dated 17 August 2018 did not refer to the underlying facts of the incident at all nor was there any reference to the facts of the incident in Colleague A's witness statement.

Therefore, the panel was not satisfied that on the balance of probabilities on or before 17 August 2018 changes of behaviour and / or concerns with risk were not handed over to the multi-disciplinary team.

In light of the above, the panel finds this charge 5) not proved.

Charge 6)a)

6) On or around 7 September 2018:
    a) failed to evaluate and / or update care plans for unknown patients.

This charge is found proved.

In its consideration of charge 6)a), the panel first considered whether or not Mr Bangura was under a duty to do what he was alleged not to have done. The panel was satisfied that he was for the following reasons:

Colleague A explained there was an expectation and requirement for a primary nurse to evaluate their patients care plan at least once a month and also at 1:1s with patients, which should ideally take place on a weekly basis with care plans updated, to show progression.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence, her exhibits of a meeting letter dated 7 September 2018 and an action plan.

The panel considered Colleague A's witness statement in which she stated that "*I met up with Mo on 7 September 2018 to discuss his performance and set targets for him as part of his support plan. There were still some needs to review and update care plans which [Witness 7] would be providing support. Mo failed to update and evaluate these care plans. There were also concerns about his content, grammar and punctuation in the tribunal report that he had produced."* It also considered her letter dated 7 September 2018 in which she stated "*…You expressed that you need to review and update the care plans for your other Primary Patient of which you informed me of your plan to complete this over this coming weekend...*"

The panel was of the view that Colleague A's documentary evidence was consistent with her account during oral evidence. It further noted that this concern appeared to be a reoccurring theme within the action plan.

The panel determined that on the balance of probabilities Mr Bangura failed to evaluate and/or update care plans for unknown patients.

Therefore, the panel finds this charge 6)a) proved.

Charges 6)b)i)ii)iii)

6) On or around 7 September 2018:
    b) Produced a tribunal report with:
        i) Incorrect content;
        ii) Grammar errors;
        iii) Punctuation errors.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence, her exhibits of two meeting letters dated 4 October 2018 and 8 October 2018 and an action plan.

The panel did not have sight of the tribunal report nor was there any reference of the tribunal report within the action plan. It considered that in the absence of any other evidence, it could not be satisfied on the balance of probabilities that Mr Bangura produced a tribunal report with incorrect content, grammar errors and punctuation errors.

In light of the above, the panel therefore finds that the NMC has not discharged its burden of proof and finds charges 6)b)i)ii)iii) not proved.

Charge 7)a)

7) On or around 8 October 2018:
   a) did not complete a CPA report for Patient D;

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a meeting letter dated 7 November 2018.

The panel considered Colleague A's witness statement in which she stated that "*On 8 October 2018, Mo's first review meeting, he was not meeting the Primary Nursing Standards under the Trust Capability Policy. I gave him the entire shift to complete the CPA report but this remained incomplete*." However, during Colleague A's oral evidence she confirmed that she could not recall any detail around this reference in her statement.

It further considered Colleague A's letter dated 7 November in which she stated "*We then took time to reflect on our last meeting held on 30 October 2018 whereby, I informed you of my concerns regarding your Primary Patient D's 1:1s and Care Plans. This is also documented in letter dated 02 November 2018*" and "*I reminded you that following this meeting you reassured me that this would be completed by the end of your shift. To support you in this we approached the Nurse in Charge of the shift and requested for time to be allocated to enable you to complete this, however, this remains incomplete to date*." The panel was of the view that there is documentary evidence to suggest that Patient D's care plans have not been completed however, it does not specifically state that a CPA report for Patient D was not completed.

Given the nature of the evidence, the panel was not satisfied, on the balance of probabilities Mr Bangura did not complete a CPA report for Patient D.

Therefore, the panel finds this charge 7)a) not proved.

Charge 7)b)

7) On or around 8 October 2018:
   b) did not complete one or more care plans for an unknown patients.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibits of two meeting letters dated 8 October 2018 and 30 October 2018.

The panel considered Colleague A's witness statement in which she stated that "*There were new admissions and there were three care plans that were also not completed. Mo reported that he had finished all of them however, had not saved them on RiO. He also reported not to have completed the physical care aspect on one of them. For this particular patient, we were concerned about the physical health and therefore, it was important to ensure that this had been completed to enable us to provide the appropriate care and treatment*." The panel noted that the meeting records were contemporaneous and consistent. It further noted that this concern was a reoccurring theme running through subsequent performance review meetings. The panel was satisfied that on the balance of probabilities Mr Bangura did not complete one or more care plans for an unknown patients.

Therefore, the panel finds this charge 7)b) proved.

Charge 8)

8) Between 1 October 2018 to 31 October 2018 you recorded one primary nurse 1:1 session on RIO for Patient D.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibits of three meeting letters dated 30 October 2018, 2 November 2018 and 7 November 2018.

The panel considered Colleague A's letter dated 30 October 2018 in which she stated that "*I also informed you that your Primary Patient D only appears to have one, Primary Nurse 1:1 session recorded on RiO for the month of October. I therefore, reiterated the importance of providing our patients with the care that they are entitled to and deserve*."

Colleague A in her oral evidence told the panel that there needed to be a minimum of one 1:1 meeting per week between the primary nurse and the patient. She said that the meeting needed to be recorded on RIO which would equate to four entries per month. Colleague A explained that Mr Bangura said he was slow at typing. In response to this Colleague A further told the panel that she authorised the ward administrator to carry out typing for Mr Bangura. Colleague A also offered to type up the entries for Mr Bangura. However, the panel heard he chose not to utilise this support.

The panel was satisfied that on the balance of probabilities between 1 October 2018 to 31 October 2018, Mr Bangura recorded one primary nurse 1:1 session on RIO for Patient D.

Therefore, the panel finds this charge 8) proved.

Charge 9)a)

9) On or before 5 November 2018 you did not provide a copy of a CPA report:
   a) to Colleague A;

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibits of two meeting letters dated 2 November 2018 and 7 November 2018.

The panel considered Colleague A's witness statement in which she stated that "*I met up with Mo on 5 November 2018 to discuss further issues such as the Ward Administrator, patient and I did not receive a copy of a CPA report for this patient.*" It also considered Colleague A's letter dated 2 November 2018 in which she stated "*I also informed you that I had asked the Nurse in Charge not to disturb you and I reminded you that the Ward Administrator is available to type your report for you if you so wished. I requested that you send the report to me once complete for approval however; I have not received the report to date*." It further noted that Colleague A in her oral evidence told the panel that she expected to have the CPA report by the point of writing to Mr Bangura.

The panel was satisfied that on the balance of probabilities on or before 5 November 2018 Mr Bangura did not provide a copy of a CPA report to Colleague A.

Therefore, the panel finds this charge 9)a) proved.

Charge 9)b)

9) On or before 5 November 2018 you did not provide a copy of a CPA report:
   b) to Patient D.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a letter dated 7 November 2018.

The panel considered Colleague A's letter dated 7 November 2018 on which she stated that "*Furthermore, I asked you if Patient D had a copy of his care plans of which you replied that he does not. I asked you to consider how you think that he may feel upon reading his care plans and you responded by saying, he does not wish for a copy of his care plans*."

The panel noted that although Mr Bangura indicated that Patient D did not want a copy of his CPA report, Colleague A in her oral evidence told the panel that confirmed her view that the patient not wanting a copy of the report did not excuse the report not being ready for the patient before the CPA meeting.

The panel was satisfied that on the balance of probabilities on or before 5 November 2018 Mr Bangura did not provide a copy of a CPA report to Patient D.

Therefore, the panel finds this charge 9)b) proved.

Charge 10)

10) On or before 5 November 2018 you did not correctly evaluate a care plan for Patient D.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a letter dated 7 November 2018.

The panel considered Colleague A's witness statement in which she stated that "*It was also evident that this patient care plan had not been evaluated appropriately*. *This patient had progressed well and his presentation had improved but this was not evaluated in the care plan. This is important for patient safety reasons and in order for the patient's progression and development. In addition to ensure that the team are up to date with the patient's current mental health state and plans moving forward. It would also be detrimental to a patient to read that their progress had not been updated…*" It also considered Colleague A's letter dated 7 November 2018 in which she stated that "*I noted that Patient D's care plans reflected his presentation upon admission and I emphasised that his presentation has significantly improved since admission however; this is not evaluated in the care plans*."
The panel was satisfied that on the balance of probabilities on or before 5 November 2018 Mr Bangura did not correctly evaluate a care plan for Patient D.

Therefore, the panel finds this charge 10) proved.

Charge 11)

11) On 7th November 2018 you provided a negative view of Patient A during a CPA meeting.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's, Witness 4's and Witness 5's witness statements and oral evidence. It also took into account Colleague A's exhibit of a letter dated 26 November 2018, an action plan and a capability policy/report.

The panel considered Witness 4's witness statement in which he stated that "*The Registrant's feedback about the patient was uniformly negative and critical. It was as if the Registrant thought that his role within the meeting was to reprimand the patient for his antisocial behaviour. The Registrant did not provide any context to his comments and I don't recall him describing any positive aspects of the patient's presentation. I thought that the Registrant was being punitive and did not attempt, nor understood the need to be therapeutic. Whilst listening to the Registrant's feedback, the patient and his relatives looked distressed and uncomfortable*." Witness 4 in his oral evidence told the panel that Mr Bangura listed a litany of Patient A's bad behaviours during the meeting which was not appropriate and that it would have been demoralising and embarrassing for Patient A to hear Mr Bangura say those things. Witness 4 expected Mr Bangura as a band 5 nurse to be able to present appropriately during a CPA meeting.

It also considered Witness 5's witness statement in which she stated that "*I did not report the incident to anyone, but it would have been bought up with the clinician present informally of how uncomfortable it was. [Witness 4] may have raised it with the registrant's manager, but I am not sure. In all my years of attending CPA meeting I have never witnessed such negative feedback as the registrant demonstrated towards the patient*."

During Witness 5's oral evidence she told the panel that Mr Bangura focused on a list of what had not gone well for the patient and that he approached the meeting in a punitive way.

The panel further considered Colleague A's witness statement in which she stated that "*The patient can invite someone, normally a relative to come to a CPA meeting. Mo portrayed a negative picture of this particular patient during the meeting while the relatives were present. A couple of the team members reported that they had felt uncomfortable during this meeting. The Responsible Clinician (RC) said that he felt that the patient would have found this experience alienating he said that he appeared upset and frustrated with the negative feedback of which was a shame because the patient had many positive aspects. This could have increased the risk of safety for all in the meeting*" and "*During such meetings, it's important to focus on positive aspects. Mo did not appear to understand how this would cause distress to the family or the patient. It can also increase the risk for everyone in the room as the patient may have reacted negatively and an incident could have occurred as a result*."

The panel also considered Colleague A's letter dated 26 November 2018 in which she stated that "*On listening to this feedback you expressed to me that you did not feel that this was an accurate account of the meeting. You said that: "I cannot go into a CPA Meeting and lie about the patient'. I explained to you that you would not be expected to 'lie' however, careful consideration in terms of how feedback is articulated in such meetings with our patients is very important. I agreed that at times it may be appropriate to give patients negative feedback in a group setting, however, when this is the case, it needs to be planned carefully so that the precise message and its probable impact can be thought about. More importantly, CPA Meetings should never be a traumatising experience for our patients*".

The panel determined that on the balance of probabilities on 7 November 2018 Mr Bangura provided a negative view of Patient A during a CPA meeting.

Therefore, the panel finds this charge 11) proved.

Charge 12)

12) On 7 November 2018 did not complete a physical health assessment for Patient F.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's and Witness 4's witness statements and oral evidence. It also considered Colleague A's exhibit of a letter dated 26 November 2018.

The panel took into account Witness 4's oral evidence where he requested that Mr Bangura arrange a team to assess a patient who has been lying immobile and unresponsive in a seclusion area for some time. In his statement Witness 4 asserted that Mr Bangura "*said it would not be possible to enter the room*."

The panel considered Witness 4's witness statement in which he stated that "*Entering a seclusion room is a high risk intervention which requires careful planning and a minimum of three nurses. The nurse in charge of a shift has overall responsibility for overseeing the care of all patients on their ward and planning interventions such as entering a seclusion room. A nurse in charge of a shift should know that further assessment of a patient who is unresponsive and immobile is essential. The Registrant did not appear to grasp the seriousness of the situation and the need to intervene."*

Witness 4 in his oral evidence confirmed that Mr Bangura either needed to do an assessment himself or escalate the matter to the medical team. Witness 4 recalled that Mr Bangura seemed "*blasé*" about the whole incident. He confirmed to the panel that there was no information forthcoming from Mr Bangura about Patient F.

Witness 4 in his witness statement explained that he was concerned that "*at that stage, the registrant had not made any plans to enter the patients' room to review him*." Witness 4 told the panel following his exchange with Mr Bangura he immediately escalated the matter to senior nursing staff who facilitated the patients review.

The panel also noted that Colleague A was approached by Witness 4 at this time regarding this incident and his concerns. The panel also considered Colleague A's letter to Mr Bangura dated 26 November 2018 which stated that "*You explained to me that you intended to communicate with the patient and to encourage fluids during the afternoon*."

The panel determined that on the balance of probabilities on 7 November 2018, Mr Bangura did not complete a physical health assessment for Patient F.

Therefore, the panel finds this charge 12) proved.

Charge 13)a)

13) On or before 17 December 2018:
    a) did not implement a management plan.

This charge is found NOT proved.

The panel noted that there is no evidence to support this charge. The reference to a "*management plan*" was included in Colleague A's witness statement about Mr Bangura assessing Patient F during the 7 November 2018 incident as per charge 12) above.

The panel was not satisfied that on the balance of probabilities on or before 17 December 2018, Mr Bangura did not implement a management plan.

Therefore, the panel finds this charge 13)a) not proved.

Charges 13)b)c)d)

13) On or before 17 December 2018:

b) on one or more occasions did not record your interaction with unknown patients on RiO.

c) did not produce the required standard of content for care plans.

d) did not produce the required standard of content for written reports.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's oral evidence and her exhibit of a letter dated 24 December 2018.

The panel noted that charges 13)b to 13)d) derived from the letter dated 24 December 2018 from the meeting held on 17 December 2018. Colleague A in her oral evidence told the panel that 13)b), 13)c) and 13)d) were a summary of previous incidents that had already occurred. Colleague A did not suggest that these were new examples of concerns on 17 December 2018, but the reference was to previous occurrences over previous months. The panel noted that these incidents were subject to earlier charges. The panel was not satisfied that on the balance of probabilities on or before 17 December 2018, on one or more occasions Mr Bangura did not record his interaction with unknown patients on RiO, did not produce the required standard of content for care plans and did not produce the required standard of content for written reports.

Therefore, the panel finds charges 13)b), 13)c) and 13)d) not proved.

Charge 14)a)

14) On or before 18 March 2019:

a) did not complete one or more care plans for unknown patients;

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a letter dated 19 March 2019.

The panel noted that it has not been provided with any evidence to suggest that Mr Bangura did not complete the care plans. It noted that eventually Mr Bangura did complete the care plans albeit not in the required time frame. The panel was not satisfied that on the balance of probabilities that Mr Bangura did not complete one or more care plans for unknown patients.

Therefore, the panel finds charge 14)a) not proved.

Charge 14)b)

14) On or before 18 March 2019:

b) did not record your 1:1 primary nurse sessions on RiO in a timely manner.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's witness statement, oral evidence and her exhibit of a letter dated 19 March 2019.

The panel considered Colleague A's witness statement in which she stated that "*I met up with Mo again on 18 March 2019 to discuss his Primary Nursing Standards and leadership. Only 3 of his 6 care plans were completed so the remaining were not completed in the required time frame. Mo received support in terms of allocated office time and support from a colleague. Mo was still not recording his 1:1 Primary Nurse sessions on RiO in time.*" It also considered Colleague A's letter dated 19 March 2019 in which she stated that "*As you are aware you were required to complete the 6 Core Care Plans for your new Primary Patient. As per your support plan the Care Plans should have been completed within a week of admission. Preceptorship Nurse JE kindly assisted you with 3 of these Care Plans however, despite this you did not complete the remaining care plans within the required time frame. However, you did provide reassurance during this meeting that the Care Plans are now all completed and on RiO*."

The panel determined that on the balance of probabilities Mr Bangura did not record his 1:1 primary nurse sessions on RiO in a timely manner.

Therefore, the panel finds this charge 14)b) proved.

Charges 15)a) and 15)b)

15) on or before 4 February 2020:
   a) on one or more occasions did not delegate roles;
   b) did not communicate clearly and / or concisely.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's statement and oral evidence.

The panel considered Witness 1's witness statement in which he stated that "*On 5 February 2020, we had a three month review with Mo. We identified the areas to work on was delegation and communication. Mo lost the ability to lead. Leading is essentially for the role he was in. When distributing duties, Mo was not able to do this well due to his confidence issue. He did not have a good working relationship. Mo chose to do most the roles without distributing them out equally. I was pointing out to Mo that he should delegate more often. Mo's communication also lacked clarity and he was not concise...*"

Witness 1 in his oral evidence was unable to provide specific dates of incidents but he stated that Mr Bangura had stopped communicating and his communication became minimal. Witness 1 told the panel that Mr Bangura would not be clear about what he wanted done and who was going to do it. He stated that Mr Bangura would do things himself rather than delegating as he was expected to do so as a nurse in charge. However, the panel was of the view that in relation to this charge the documentary evidence contained general statements. Although, Witness 1 in his evidence makes reference to delegation and communication he was unable to provide the panel with specific examples of such incidents taking place.

The panel was not satisfied that on the balance of probabilities that Mr Bangura on one or more occasions did not delegate roles and did not communicate clearly and/or concisely.

Therefore, the panel finds charges 15)a) and 15)b) not proved.

Charge 16)a)

16) On 4 March 2020 you:

a) did not know where the second line emergency drugs were located.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement, oral evidence and her exhibit of the Medicine Round Assessment for Mr Bangura dated 4 March 2020.

The panel considered Witness 2's witness statement in which she stated that "*In every ward medicine cabinet, there is a collection of second line emergency drugs stored in a red basket for use in an acute medical emergency. There is a poster the cabinet door indicating the location of the basket and detailing the contents. Some of the contents include adrenaline for anaphylaxis, salbutamol inhaler for asthma attack, PR diazepam for seizures etc.*"

It further considered that Witness 2 stated "*During the assessment I asked Mohamed where the emergency drugs were kept; whilst he and I were standing directly in front of the open medicine cabinet. Mohamed thought the emergency medicines were kept in site management, an office on the opposite end of the hospital site which was far too far away to be practical in an emergency. Once I had indicated to him where the red basket and the poster was, I laid out the contents of the red basket on the counter and asked him what he knew about them. Mohamed did not appear to be familiar with the majority of the medicines, how they are administered or the conditions they are used for*." It was of the view that Witness 2's evidence was credible and consistent.

The panel noted that Witness 2's evidence was supported by the Medicine Round Assessment for Mr Bangura dated 4 March 2020.

The panel determined that on the balance of probabilities Mr Bangura did not know where the second line emergency drugs were located.

Therefore, the panel finds this charge 16)a) proved.

Charges 16)b)i) and 16)b)ii)

16) On 4 March 2020 you:
    b) did not know how the second line emergency drugs were;
        i) Administered;
        ii) Conditions they were used for.

This charge is found proved.

In reaching this decision, the panel took into account the evidence considered in respect of charge 16)a).

The panel considered Witness 2's witness statement in which she stated that "*I was concerned with Mohamed's lack of knowledge in this area. An inability to locate emergency drugs quickly, not knowing the appropriate medicines to use or how to administer them could have potentially life threatening consequences in an acute medical emergency situation*" and "*After the assessment, I spent time with Mohamed going through all of the emergency medicines, how to administer them and what conditions they are used for*." The panel determined that on the balance of probabilities Mr Bangura did not know how the second line emergency drugs were; administered and the conditions they were used for.

The panel noted that Witness 2's evidence was supported by the Medicine Round Assessment for Mr Bangura dated 4 March 2020.

Therefore, the panel finds charges 16)b)i) and 16)b)ii) proved.

Charge 16)c)

16) On 4 March 2020 you:

c) You prepared and / or administered medication without checking the prescriptions against Patient 5 and / or Patient 6 consent forms.

This charge is found proved.

In reaching this decision, the panel took into account the evidence considered in respect of charge 16)a).

The panel considered Witness 2's witness statement in which she stated that "*During the first assessment I observed Mohamed preparing and administering medication to the first and the second patient without checking the prescriptions against their respective consent forms. He hadn't picked the documents up, when he took each prescription card from the suspension file (all documents and prescriptions are kept together in this). I collected the consent forms and cross checked the prescriptions myself whilst I observed Mohamed administer, he appeared unaware of my checking*." The panel noted that Witness 2 provided a detailed account on how medications are administered and how it is checked against prescription and consent forms.

The panel determined that on the balance of probabilities Mr Bangura prepared and/or administered medication without checking the prescriptions against Patient 5 and/or Patient 6 consent forms.

The panel noted that Witness 2's evidence was supported by the Medicine Round Assessment for Mr Bangura dated 4 March 2020.

Therefore, the panel finds charge 16)c) proved.

Charge 16)d)

16) On 4 March 2020 you:

d) You did not identify the consent form when checking the prescription of Patient 7.

This charge is found proved.

In reaching this decision, the panel took into account the evidence considered in respect of charge 16)a).

The panel considered Witness 2's witness statement in which she stated that "*For the third patient, I stopped Mohammed to remind him of the requirement to check the prescription against the consent form. He then preceded to take the document wallet containing all the related documents. He picked out one of the documents and appeared to struggle to find the medicines to compare for some time. What he was actually looking at was the capacity assessment, he did not appear recognise the difference, despite the fact that consent forms and capacity assessments quite different documents*." The panel further considered Witness 2's oral evidence in which she told the panel, "*He seemed to struggle to recognise the form*" and "*He was silent and confused when I pointed out the correct form.*"

The panel noted that Witness 2's evidence was supported by the Medicine Round Assessment for Mr Bangura dated 4 March 2020.

The panel determined that on the balance of probabilities Mr Bangura did not identify the consent form when checking the prescription of Patient 7.

Therefore, the panel finds charge 16)d) proved.

Charges 17)a) and 17)b)

17) On one or more of the following dates you did not pass the Medicine Administration and / or Safe Storage Practice Standards Assessment:
    a) 4 March 2020.
    b) 22 April 2020.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement, oral evidence and her exhibits of the Medicine Round Assessments for Mr Bangura dated 4 March 2020 and 22 March 2020.

The panel considered Witness 2's witness statement in which she stated that "*I conducted medicine administration assessments with Mohamed three times. The first on the 4 March 2020, the second on the 22 April 2020, the last on the 5 June 2020*" and "*After the first assessment, I signed the competencies on the assessment document that I observed and indicated areas to improve on before I could sign them. I completed an action plan for Mohamed at the bottom, containing tasks to improve on the areas required. I also sent him copies of local policies and information related to his action plan and met with him for 1:1 teaching and support session prior to his second assessment*."

The panel also considered Witness 2's witness statement in which she stated that "*For the second assessment I added to the same assessment document, he had made some improvements, so I was able to sign a few more competencies. However, there were still competencies that needed further improvement, I completed a second action plan and met with him for 1:1 teaching support session prior to his third assessment.*"

The panel noted that Witness 2 in her statement stated that "*I was surprised that during my initial assessments, Mohamed was not able to demonstrate the basic medicine administration knowledge and skills that I would expect from every registered mental health nurse in practice, given the number of years that Mohammed had been practicing*."

The panel noted that Witness 2's evidence was supported by the Medicine Round Assessments for Mr Bangura dated 4 March 2020 and 22 March 2020.

The panel determined that on the balance of probabilities on one or more of the following dates Mr Bangura did not pass the Medicine Administration and/or Safe Storage Practice Standards Assessment on 4 March 2020 and 22 April 2020.

Therefore, the panel finds charges 17)a) and 17)b) proved.

Charge 18)

In its consideration of all the aspects alleged in this charge the panel first considered whether Mr Bangura was under a duty to do what he is alleged to have failed to do.

Witness 1 emphasised that as the primary nurse Mr Bangura needed to be aware of all relevant information relating to his patient and had responsibility for ensuring that it was documented accurately within the CPA Nursing Report dated 25 February 2020.

Charge 18)a)

18) On or before 6 March 2020 failed to produce the required content for Patient G's CPA nursing report by:
    a) Not recording they had yellow ground access;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, oral evidence and his exhibits of a CPA Nursing Report dated 25 February 2020 and an email from Witness 1 to Mr Bangura dated 9 March 2020.

The panel considered Witness 1's witness statement in which he stated that "*Mo had a primarily patient. Within the CPA report, Mo stated that he was applying for parole. On 9 March 2020, I raised a concern with Mo that he was not aware that a patient already had yellow parole. This was concerning as he did not Know this for his primary patient which the primary nurse should know*."

It considered the email dated 9 March 2020 in which Witness 1 stated "*You stated that Patient G wants to apply for Yellow Parole. To my knowledge, we spoke about this in his last CPA meeting and this was granted on the 18th of September 2019. It is therefore concerning to me that you were not aware that your patient already has yellow ground access*."

The panel noted that Witness 1's evidence was supported by a CPA Nursing Report dated 25 February 2020 and an email from Witness 1 to Mr Bangura dated 9 March 2020.

The panel determined that on the balance of probabilities on or before 6 March 2020, Mr Bangura failed to produce the required content for Patient G's CPA nursing report by not recording they had yellow ground access.

Therefore, the panel finds charge 18)a) proved.

Charge 18)b)

18) On or before 6 March 2020 failed to produce the required content for Patient G's CPA nursing report by:
    b) Including IR1's from 2 October 2018;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, oral evidence and his exhibit of a CPA Nursing Report dated 25 February 2020.

The panel considered Witness 1's witness statement in which he stated that "*Mo had also included an incident report ("IR1's") dating back to October 2019 on an upcoming CPA meeting. This CPA meeting was to review progress for the last 6 months so it was not necessary to include this for the last 6 month progress*."

The panel noted that Witness 1's evidence was supported by a CPA Nursing Report dated 25 February 2020 and an email from Witness 1 to Mr Bangura dated 9 March 2020.

The panel determined that on the balance of probabilities on or before 6 March 2020, Mr Bangura failed to produce the required content for Patient G's CPA nursing report by including IR1's from 2 October 2018.

Therefore, the panel finds charge 18)b) proved.

Charge 18)c)

18) On or before 6 March 2020 failed to produce the required content for Patient G's CPA nursing report by:
    c) Not recording they had their rights read to them under section 132 of the Mental Health Act on 24 January 2020.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, oral evidence and his exhibits of a CPA Nursing Report dated 25 February 2020 and an email from Witness 1 to Mr Bangura dated 9 March 2020.

The panel considered Witness 1's witness statement in which he stated that "*Thirdly, Mo had written on the report that the patient had his rights read last on 15 August 2019. If this was the case then Mo should have read the patient his rights as 6 months have elapsed. But this patient actually had his rights read on 24 January 2020 by another staff member and Mo was not aware of this*."

The panel had regard to the CPA Nursing Report dated 25 February 2020 in which it was stated that "*On 15th August 2019, Patient G was given his statutory information (section 132 of the MHA 1983*." The panel was of the view that the report suggest the last time Patient G's rights were read out was on 15 August 2019, which occurred more than 12 months ago.

The panel also considered the email dated 9 March 2020 in which Witness 1 stated that "*You stated that your patient last had his rights read to him under section 132 MHA on the 15th of August 2019. This date was before his previous CPA meeting. As expected of you, I am sure you know that this is done every 6 months and according to the records, His rights were last read to him on the 24th of January 2020 by...This is also concerning to me that you were not aware of this*."

The panel noted that Witness 1's evidence was supported by a CPA Nursing Report dated 25 February 2020 and an email from Witness 1 to Mr Bangura dated 9 March 2020.

The panel determined that on the balance of probabilities on or before 6 March 2020, Mr Bangura failed to produce the required content for Patient G's CPA nursing report by not recording they had their rights read to them under section 132 of the Mental Health Act on 24 January 2020.

Therefore, the panel finds charge 18)c) proved.

Charge 18)d)

18) On or before 6 March 2020 failed to produce the required content for Patient G's CPA nursing report by:
    d) Did not record an incident that occurred 6 October 2019.

This charge is found proved.

In its consideration of charge 18)d), the panel first considered whether or not Mr Bangura was under a duty to do what he was alleged not to have done. The panel was satisfied that he was for the following reasons:

In reaching this decision, the panel took into account Witness 1's witness statement, oral evidence and his exhibits of a CPA Nursing Report dated 25 February 2020 and an email from Witness 1 to Mr Bangura dated 9 March 2020.

The panel considered Witness 1's witness statement in which he stated that "*Mo also forgot to include an emergency which happened on 6 October 2019 to the report although this may simple have been an oversight*."

The panel also considered the email dated 9 March 2020 in which Witness 1 stated that "*I know your leave starts today although you agreed to come in to present your patient's CPA report tomorrow. I hope you spent time to discuss the report with your patient as is expected of you. I need to point out to you a few concerns I have with regards to your 26 Page report which I believe should be summarised and still remain as reflective of your patient's progress in the last 6 months… you asked me to give you a call regarding the report before you present it tomorrow. I hope you address the above before you present this report in the meeting*."

The panel considered the email dated 9 March 2020 where Witness 1 informed Mr Bangura "*[PRIVATE]*".

The panel noted that Witness 1's evidence was supported by a CPA Nursing Report dated 25 February 2020 and an email from Witness 1 to Mr Bangura dated 9 March 2020.

The panel determined that on the balance of probabilities on or before 6 March 2020, Mr Bangura failed to produce the required content for Patient G's CPA nursing report by not recording an incident that occurred 6 October 2019.

Therefore, the panel finds charge 18)d) proved.

Charge 19)a)

19) On one or more of the following dates did not correctly use the Z tracking technique to administer IM depot injections:
    a) 26 March 2020.

This charge is found NOT proved.

The panel noted that there was no evidence that any staff members observed Mr Bangura on 26 March 2020 attempting to or using the Z tracking technique. The panel was not satisfied that on the balance of probabilities that on one or more of the following dates Mr Bangura did not correctly use the Z tracking technique to administer IM depot injections on 26 March 2020.

Therefore, the panel finds charge 19)a) not proved.

Charge 19)b)

19) On one or more of the following dates did not correctly use the Z tracking technique to administer IM depot injections:
    b) To Patient 9 on 24 April 2020

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, oral evidence and his exhibit including an email from Witness 1 to Mr Bangura dated 24 April 2020.

The panel considered Witness 1's witness statement in which he stated that "*I observed Mo again trying to use the approved Z tracking method for depot injection, Olanzapine on 24 April 2020. While Mo did check the expiry date and prepare the injection well, he failed to use the technique*." It also considered the email dated 24 April 2020 in which Witness 1 stated that "*You checked the expiry date and then went on to prepare the injection well. Unfortunate when you injected the patient, you did not use the Z-tracking technique as agreed beforehand. When I saw the patient off and came back to give you feedback, you told me straightaway that you are aware you had made a mistake. You told me that you had not used the Z-tracking method. When I asked you why you had not done so, you told me that you did not have any excuse at all*." The panel was of the view that Witness 1 observed Mr Bangura who did not correctly use the Z tracking technique.

The panel determined that on the balance of probabilities that on one or more of the following dates Mr Bangura did not correctly use the Z tracking technique to administer IM depot injections to Patient 9 on 24 April 2020.

Therefore, the panel finds charge 19)b) proved.

Charge 20)

20) On or before 26 March 2020 failed to produce the required content for Patient 10's CPA report by recording out of date information.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement, oral evidence and his exhibit including an email from Witness 1 to Mr Bangura dated 26 March 2020.

The panel considered Witness 1's witness statement in which he stated that "*There were also concerns with Mo's CPA report. I felt he was copying and pasting from previous reports or using it as a template so it had old information on it. This is not the correct process of writing these reports as there is a high likelihood of mistakes happening. The correct process is starting from scratch*."

The panel also considered the email dated 26 March 2020 in which Witness 1 stated that **"***We discussed the report you submitted to myself via email before you went on leave. I pointed out my concerns regarding this report and that it was below the expected standard. You became very argumentative about some of the contents in the report saying you did not write them. You denied "copying and pasting" from previous reports and you told me that you were given a "template" which you deleted and may have forgotten to delete some things...*" However, the panel was of the view that it did not have any evidence to suggest what the required content of the CPA report was and what did Mr

Bangura fail to produce. The panel noted that Mr Bangura in this discussion with Witness 1 denied the failing of copying and pasting from previous reports. The panel has not had sight of this report.

The panel was not satisfied that on the balance of probabilities that on or before 26 March 2020 Mr Bangura failed to produce the required content for Patient 10's CPA report by recording out of date information.

Therefore, the panel finds charge 20) not proved.

Charge 21)a)

21) On 17 April 2020 you:
    a) failed to call site management to organise extra staff for an escort of unknown patients to the patient shop;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence. It also considered Witness 6's oral evidence and her exhibit of an email from Witness 6 to Mr Bangura dated 18 April 2020.

The panel considered Witness 1's witness statement in which he stated that *"Mo was NIC on 16 and 17 April 2020. I received feedback from TL [Witness 6] who said that Mo still struggled with leadership and to take charge... [Witness 6] stated that Mo failed to call site management to organise extra staff for an escort of patients to the patients shop, failed to make a list of patients attending, and unsure on who should be allocated for escorting patients. [Witness 6] concluded that there was still much work to be done for when Mo is Nurse in Charge."*

The panel also considered the email dated 18 April 2020 to Mr Bangura in which Witness 6 stated that "*I expected from you as the Nurse in Charge to contact Site Management to organize support, however once again I found myself calling Site Management and arranging extra staff.*" Witness 6 in her oral evidence confirmed the contents of this email to the panel.

The panel determined that on the balance of probabilities that Mr Bangura failed to call site management to organise extra staff for an escort of unknown patients to the patient shop.

Therefore, the panel finds charge 21)a) proved.

Charge 21)b)

21) On 17 April 2020 you:
    b) Failed to make a list of unknown patients attending;

This charge is found proved.

In reaching this decision, the panel took into account the evidence considered in respect of charge 21)b).

The panel considered the email dated 18 April 2020 in which Witness 6 stated that "*During the process of organizing canteen as much as you were involved in activities which were going on at that time on the floor, you did not complete the list of patients which were attending and you were unsure who should be allocated for escorting patients*." The panel determined that on the balance of probabilities that Mr Bangura failed to make a list of unknown patients attending.

Therefore, the panel finds charge 21)b) proved.

Charge 21)c)

21) On 17 April 2020 you:

c) You did not know who should be allocated to escort unknown patients.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's exhibit of an email from Witness 6 to Mr Bangura dated 18 April 2020.

The panel considered the email dated 18 April 2020 in which Witness 6 stated that "*you were unsure who should be allocated for escorting patients*." Witness 6 in her oral evidence was unsure what she meant by this due to the passage of time therefore the panel was unable to rely on this evidence.

The panel was not satisfied that on the balance of probabilities that Mr Bangura did not know who should be allocated to escort unknown patients.

Therefore, the panel finds charge 21)c) not proved.

Charge 22)

22) On 29 August 2020 you allowed Patient B to move around the ward without keeping them in your sight at all times.

This charge is found proved.

In reaching this decision, the panel took into account Witness 12's witness statement, oral evidence and her exhibit of Witness 12's local statement dated 8 October 2020 and a Datix Report.

Witness 12 in her oral evidence explained another member of staff reported observing Patient B walking to the ward dining room alone.

The panel considered Witness 12's witness statement in which she stated that "*[PRIVATE]… Mo was undertaking an observation from 17:00 to 18:00 which means he would be outside the bedroom door sitting on a chair and the door would be open. The patient would have to walk past Mo to enter the dining room and other communal areas. I had a conversation with the patient to check on them. I sat with her near the staff office. She told me that she had been in the bedroom and walked out. She wandered about and went into the dining room. Her general feeling was that she felt unsafe of managing her own safety with the staff member…*"

Witness 12 in her oral evidence confirmed that Patient B was able to move around the ward without being kept under direct observation and Witness 12 also spoke to Patient B in person who confirmed this. Witness 12 confirmed that when Patient B was in the dining room she would have been out of Mr Bangura's line of vision.

The panel determined that on the balance of probabilities that on 29 August 2020 Mr Bangura allowed Patient B to move around the ward without keeping them in his sight at all times.

Therefore, the panel finds charge 22) proved.

Charge 23)a)

23) On 17 September 2020 you:
    a) instructed staff to open the place-of-safety door;

This charge is found proved.

In reaching this decision, the panel took into account Witness 8 and 9's witness statements and oral evidence.

The panel considered Witness 8's witness statement in which she stated that "*Mo shouted for someone to pull the PIT alarm so I did…and Mo then shout to open the door. I assumed he was informal so opened the door*." It also considered Witness 9's witness statement in which she stated that *"At the same time as [Witness 8] pulled the alarm, Mo instructed [Witness 8] to open the door."*

The panel determined that on the balance of probabilities that Mr Bangura instructed staff to open the place-of-safety door.

Therefore, the panel finds charge 23)a) proved.

Charge 23)b)

23) On 17 September 2020 you:

b) allowed Patient C to leave the building;

This charge is found proved.

In reaching this decision, the panel took into account Witness 8, 9 and 10's witness statements and oral evidence. It also considered Witness 10's exhibit of her local statement.

The panel considered Witness 8's witness statement in which she stated that "*The patient went to go the wrong way so I started to follow him but…told me to get back inside POS as he was dangerous and close the door, so I did*." It also considered Witness 9's witness statement in which she stated that *"[Witness 8] did this and Patient C ran out of the unit. When Patient C got out the unit we followed after him this was after being instructed by Mo to wait behind the door whilst he goes out*."

It further considered Witness 10's witness statement in which she stated that "*I bumped into the support workers, [Witness 8] who was on shift and she said to me that the Nurse, Mohamed told them to let the patient out. They had informed me that the patient was quite aggressive.*" Witness 10 in her local statement stated that "*I was initially in POS 3 and heard an alarm, so I went to reception to find out what was happening. I saw a lot of people at the main entrance, including the DSN. I asked her what happened and she informed me that the POS staff had let the patient out of POS. At this point I knew the patient had been detained on section 2 and my initially assumption was that there was confusion around his legal status*."

The panel determined that on the balance of probabilities that Mr Bangura allowed Patient C to leave the building.

Therefore, the panel finds charge 23)b) proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and or misconduct and if so, whether Mr Bangura'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 a lack of competence and or misconduct. Secondly, only if the facts found proved amount to lack of competence and or misconduct, the panel must decide whether, in all the circumstances, Mr Bangura's fitness to practise is currently impaired by reason of either or both of them.

Submissions on a lack of competence and misconduct

Mr Kewley, in his written submissions dated 4 August 2023, stated that:

*'**Introduction***

1. *The questions for the panel at this stage are as follows:*
   a. *Do any of the facts found proved amount to either lack of competence or misconduct?*
   b. *If so, is the Registrant's fitness to practise currently impaired?*

2. *At this stage there is no burden of proof on either party.*

3. *These written submissions make reference to the combined transcript bundle provided to the panel (running to 408 pages). Page references in this document refer to the electronic PDF numbering i.e 'page 100' refers to page 100 of the PDF numbering as opposed to any internal pagination on the pages of the transcripts. 'TB' throughout refers to 'transcript bundle' i.e TB page 100.*

Lack of competence

4. *In Calhaem v General Medical Council [2007] EWHC 2606 (Admin), Jackson J provided the following guidance at [39]:*

‘From this review of the authorities, I derive five principles which are relevant to the present case:
(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct".

(2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct".

(3) "Deficient professional performance" within the meaning of 35C(2)(b) is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.

(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance".

(5) It is neither necessary nor appropriate to extend the interpretation of "deficient professional performance" in order to encompass matters which constitute "misconduct".’

5. *There is no statutory definition of lack of competence. Much of the case law derives from cases concerning the General Medical Council’s equivalent to lack of competence known as ‘deficient professional performance’.*

6. *NMC guidance FTP-2B reflects the comments of Jackson J in Calhaem in the following terms: 'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.'*

7. *The panel will need to consider, therefore, whether the facts found proved amount to a lack of competence in the sense that:*
   a. *The Registrant's* ***standard of professional performance was unacceptably low****; and*
   b. *The facts found proved* ***represent a fair sample*** *of the Registrant's work.*

Misconduct

8. *There is no statutory definition of misconduct.*

9. *In Roylance v General Medical Council (no.2) [2000] 1 A.C 311, Lord Clyde held that: 'misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'*

10. *Subsequent case law has confirmed that misconduct must be 'serious' (see, for example, Elias J in Remedy v General Medical Council [2010] EWHC 1245 (Admin) at paragraph [37]).*

Submissions on lack of competence/misconduct

11. *The NMC's view is that with the exception of charges 22 and 23, the facts found proved are more akin to lack of competence than misconduct. The panel will recall the evidence of experienced nurse [Witness 7] (**TB page 196**): "I do not think anything he was doing was malicious or bad in any way. Does that make sense? I do not think he is a bad person or a person of poor character. I just do not think he, at that time when we went through all these processes with him, I do not think at that time he would be, my observations, deemed fit to practise as a nurse. **He just did not have the level of skills, the competency or demonstrate the level of skills or competency and understanding to be a first level nurse in old money terms**."*

12. *In determining whether the standard of the Registrant's professional performance was unacceptably low, the panel may be assisted by the following provisions of The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2015):*

    1.2 Make sure you deliver the fundamentals of care effectively
    6.2 Maintain the knowledge and skills you need for safe and effective practice
    10 Keep clear and accurate records relevant to your practice
    10.1 Complete all records at the time or as soon as possible after and event
    10.2Complete all records accurately

13. *In all of the circumstances, the panel may feel that the charges (except charges 22 and 23) amount to a lack of competence in that they demonstrate that the Registrant's performance was at an unacceptably low standard. The charges concern multiple areas of the Registrant's practice including record keeping/documentation, care planning, patient communication and clinical skills/knowledge. These are basic and fundamental areas of nursing required for safe and effective practice as a nurse. A lack of competence in basic and fundamental areas of nursing practice plainly increases risk to patients. The Registrant was unable to achieve a sustained level of improved performance to the required standard in spite of extensive support from the team at Broadmoor Hospital. The facts found proved plainly represent a fair sample of the Registrant's work across a protracted period of time notwithstanding the periods of absence.*

Charges 22 and 23

14. *As to charge 22, the panel heard from [Witness 12] that Patient B was a particularly high risk patient [PRIVATE]… (**TB page 285**). [PRIVATE]. [Witness 12] explained that Patient B had been able to walk past the Registrant who was sat outside Patient B's room on a chair. By allowing Patient B to move around the ward without keeping her in sight at all times, the Registrant placed Patient B at an unwarranted risk of potential harm.*

15. *As to charge 23, the panel heard that Patient C had been detained under the Mental Health Act. Patient C was not, therefore, free to leave the hospital of his own will. [Witness 10] told the panel that patients who are brought to the place of safety typically present with either a risk to themselves or a risk to other people – detention under the Mental Health Act would not be considered if the person could be managed safely outside of a hospital setting (**TB page 235**). [Witness 10] recognised in her evidence that the patient was intimidating and threatening but she explained to the panel that this is what staff deal with in the place of safety on a daily basis.*

16. *[Witness 10] summarised the main issue that renders charge 23 so serious (**TB page 238**): 'For me, the main concern, and I think I have put it in my statement as well, we -- **we have to manage risk and what we are doing by opening the door is putting that risk out onto the public**. [PRIVATE]. By instructing staff to open the place of safety door, the Registrant placed both the patient and the public at an unwarranted risk of harm. As [Witness 10] stated, the Registrant effectively passed on the risk to the public who are not trained to deal with aggression.*

Impairment

17. *If the panel determine that the facts do amount to lack of competence or misconduct, the panel must next consider whether the Registrant's fitness to practise is currently impaired.*

18. *Impairment, like misconduct, is not defined within the legislation. The problem with defining impairment was identified by Dame Janet Smith at paragraph 25.46 in her seminal Fifth Report of the Shipman Inquiry (Fifth Report – Safeguarding Patients: Lessons from the Past – Proposals for the Future, 9 December 2004 cm6394): 'Some concepts are difficult to define but relatively easy to recognize when found. It is often said that elephants fall in to that category but I have never understood why; definition cannot be too difficult. However I fear "impairment of fitness to practise" will be not only difficult to define but also not easy to recognize, because (unlike recognizing an elephant) recognizing "impaired fitness to practise" involves making a value judgment'*

19. *Dame Janet Smith formulated the following questions (later quoted with approval by Cox J in CHRE v NMC & Grant [2011] EWHC 927 (Admin)) in her Fifth Shipman Report which the panel may find useful when considering current impairment: '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.'

20. *In Cohen v General Medical Council [2008] EWHC 581 (Admin), Silber J held as follows: [61] 'Any approach to the issue of whether a doctor's fitness to practice should be regarded as "impaired"* ***must take account of "the need to protect the individual patient, and the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behavior*** *of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the profession.'*

    [65] 'It must be highly relevant in determining if a doctor's fitness to practice is impaired that ***first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated****.'*

21. *In Kimmance v General Medical Council [2016] EWHC 1808 (Admin) Kerr J on the subject of insight and remediation held as follows at [66]: 'I do not much like those jargon words. They do not do much to illuminate the reality, which is that a doctor or other professional who has done wrong has to* ***look at his or her conduct with a self-critical eye****,* ***acknowledge fault****,* ***say sorry*** *and* ***convince a panel that there is real reason to believe he or she has learned a lesson from the experience****.' (emphasis added)*

22. *NMC Guidance FTP-13c provides guidance on assessing likelihood of repetition: 'Decision makers can also take into account the full circumstances of the case. The likelihood of the conduct being repeated in the future may be reduced where:*

    • The nurse, midwife or nursing associate has demonstrated sufficient insight and has taken appropriate steps to address any concerns arising from the allegations.

    • The behaviour in question arose in unique circumstances. While this may not excuse the nurse, midwife or nursing associate's behaviour, this may suggest that the risk of repetition in the future is reduced.

    • The nurse, midwife or nursing associate has an otherwise positive professional record, including an absence of any other concerns from past or current employers and of any previous action by us or another regulatory body.

    • The nurse, midwife or nursing associate has engaged with us throughout our processes.'

Submissions

23. *One of the peculiar features of this case is that there appears to be very little information about what caused the standard of the Registrant's professional performance to deteriorate during the relevant period at Broadmoor Hospital. The panel heard that prior to the period under consideration, the Registrant had practised for many years as a nurse. [Colleague A] confirmed in her evidence that there was no suggestion that there was anything particularly wrong with the Registrant's practice before he moved to Sandown Ward (**TB page 54**). As such, it is difficult to identify the issue that led to the Registrant's inability to perform to the required standard between 2017 and 2020. Some of the witnesses referred to the fact that the length of the capability proceedings would have affected the Registrant's confidence. The panel also heard that there were protracted periods of absence from work. However, the underlying cause of the issues in this case remains unclear.*

24. *Regardless of the cause of the issues, the Registrant's actions clearly had the potential to place patients at an unwarranted risk of harm. By way of example, the panel will recall [Witness 4] evidence that the manner in which the Registrant conducted the CPA meeting on 7 November was anti-therapeutic (**TB page 137 & 138**): "It was an anti-therapeutic – it potentially alienates the patient from his therapeutic team and sort of builds resentment and mistrust rather than the opposite, which is what we were aiming to do with patients."*

25. *Considering the observations of Silber J in Cohen, it is accepted that the concerns in this case are, in principle, capable of remediation. However, the panel will note that the Registrant was supported and encouraged to improve his practice whilst working at Broadmoor Hospital but was unable to reach the required standard and show sustained improvement.*

Insight

26. *It is submitted that following the Registrant's referral to the NMC, he has not meaningfully engaged with the process and has not shown any insight into how his practice fell short of the required standards and the potential risk that he presented to patients.*

27. *The panel heard some evidence that the Registrant was occasionally able to recognise his own errors. For example, [Witness 1] told the panel that the Registrant was able to immediately tell [Witness 1] that he had made an error with the Z tracking technique (**TB page 89**). However, the panel will also recall the evidence of [Witness 7] that the Registrant did not really seem to grasp the seriousness of the concerns about his practice until towards the end of the capability process (**TB page 194 and 196**).*

28. *[Witness 3] was asked whether the Registrant had shown insight and she stated that the Registrant appeared to lack insight into how serious the concerns were (**TB page 130**).*

29. *The panel also heard from [Witness 12] that the Registrant had no insight into the seriousness of releasing a detained patient into the community (**TB page 239 & 240**): "**…I felt he was being quite argumentative rather than sort of seeing the seriousness of what had happened and, you know, the potential risk that we have now just sort of put out there for members of the public.** You know, fortunately, the patient turned the wrong way when he left the hospital and he ended up walking further into the car park, rather than getting out of the hospital site. But if he had made it off the hospital site, we don't know – you know, if you are telling me that you are so concerned about your safety and this situation, you have now put that risk onto anyone that is walking down the street who would not be in a position to ask other staff members to come and help or have the training to manage that presentation. **I didn't feel that he thought about that at all or that he had that** -- you know, certainly when we were speaking at the time and I was trying to say, you know: "Did you think about medication? Why didn't you call me, because I was here, you called me earlier about other things, why didn't you call me to say this is what's happening? I could have supported, I could have guided you." There was nothing like that."*

30. *It is submitted that the Registrant lacked insight at the time of the incidents and the absence of insight continues to the present day.*

Remediation

31. *The Registrant has been subject to an interim suspension order since 3 September 2020. The only relevance of the interim order to the impairment stage is that it explains why the Registrant has been unable to strengthen his practice in a nursing capacity. However, there are many steps that a practitioner can take to strengthen their practice even whilst subject to an interim order. In this case there is no evidence that the Registrant has engaged in any reflection, attended any courses or training, completed any wider reading to inform his future practice or taken any steps at all to remediate the concerns in relation to his practice.*

32. *The panel heard that the Registrant was able to improve his medication practice (see evidence of [Witness 2] at **TB page 108**). However, in other areas he was not able to achieve a sustained level of improvement. [Witness 3] was asked about the Registrant's engagement and enthusiasm – she stated that it fluctuated and at times it was frustrating given that support was being provided yet the Registrant lacked motivation to achieve the outcomes (**TB page 130**).*

33. *The panel heard that the Registrant received significant input and support to enable him to improve. The panel heard from [Witness 3] that the Registrant received more support at Broadmoor Hospital that he would have received elsewhere (**TB page 128**). When asked why such an unusual level of support had been put in place for the Registrant, [Witness 3] explained that the Registrant had been a nurse for around 17 years and as an organisation, they did not want to see someone fail and lose their registration (**TB page 130**).*

34. *The panel also heard from [Witness 7] that he had never seen so many people involved in supporting someone (**TB page 194**). [Witness 7] also observed that the Registrant had a lack of engagement with the process (**TB page 197**): 'Yes. For me, there was a lack of engagement. There was a lack of energy in the process, and I know that is different for different people. I am quite energetic. I am quite expressive. Mr Bangura, even in the classroom experiences I have had with him before this process started, he is not one that sits and says an opinion in a classroom. He sits back and that might be his personality type, you know, but my observations, the drive, the energy that I would expect of somebody who is in a process like this – if I was in a process like that, I would be really anxious and nervous and I would be asking people questions every other day; what is happening; how am I getting on; what do you think of this. There was nothing coming back like that.'*

Public protection

35. *It is submitted that the absence of any insight and the lack of remediation demonstrate that the Registrant has not strengthened his practice. As such, the risk of repetition remains high. Any future occurrence of the facts found proved would place patients at an unwarranted risk of harm. It is submitted that the Registrant's fitness to practice is currently impaired on public protection grounds.*

Public interest

36. *The panel will be aware of the following passage of Cox J in Grant: 'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether 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.'*

37. *It is submitted that the public is entitled to expect that nurses on the register are able to deliver the fundamentals of care safely and effectively. The facts found proved show that the Registrant has been unable to practise to the required standard which has placed patients at an unwarranted risk of harm. The Registrant has not taken steps to strengthen his practice such that the risk of repetition remains high. In these circumstances public confidence in the nursing profession would be undermined in the absence of a finding of impairment.'*

The panel accepted the advice of the legal assessor which included reference to a number of 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 a lack of competence and misconduct

When determining whether the facts found proved amount to a lack of competence and or misconduct, the panel had regard to the terms of the Code.

In particular, the following standards:

'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

2 Listen to people and respond to their preferences and concerns

5 Respect people's right to privacy and confidentiality As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

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

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

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

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

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

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

The panel bore in mind, when reaching its decision, that Mr Bangura should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

Mr Kewley in his written and oral submissions invited the panel to consider whether all of the charges with the exception of charges 22) and 23) are more akin to lack of competence and misconduct. The panel carried out a comprehensive review of all the charges and is in agreement with Mr Kewley's submissions that with the exception of charges 22) and 23) the facts found proved are more akin to lack of competence. It did consider each of the charges proved and whether charges other than 22) and 23) are capable of amounting to misconduct but determined that they are not but are capable of amounting to a lack of competence.

Lack of competence

The panel noted that there were specific themes within the facts found proved such as poor recording keeping and documentation, lack of delegation, poor medicine management and administration and lack of organisational skills.

The panel had specific concerns in relation to the following facts:

In particular charge 3)a), which demonstrated that as a registered nurse it was Mr Bangura's duty to ensure confidentiality. Mr Bangura provided the wrong patients details to another inpatient. The panel was of the view that potential harm could have been caused due to this breach in confidentially and demonstrated Mr Bangura's lack of attention to detail.

In relation to charge 11), Mr Bangura failed to demonstrate he understood that this was intended to be a therapeutic meeting and that he provided uniformly negative views. Mr Bangura demonstrated an inability to understand the importance of empathy towards the patient.

In relation to charge 12), Mr Bangura did not demonstrate the required skills of a nurse in charge. Witness 4 told the panel that the patient should have been assessed as he was lying on the floor in a seclusion room. Witness 4 stated that Mr Bangura failed to grasp the seriousness of the situation.

In relation to charges 16) and 17) Mr Bangura demonstrated a lack of competence in relation to medicines management, which is a fundamental nursing role. The Medicines Management Compliance Nurse working with Mr Bangura on the repeated medication competent assessments commented at Mr Bangura's lack of basic medicines administration and medicines knowledge. Although Mr Bangura was able to demonstrate improved medicines management it took him three attempts to reach the required standard which was unusual.

In relation to charge 19)b), the panel noted that this was a basic clinical technique. The panel further noted that Mr Bangura accepted and admitted to a witness that he was not able to apply the "*Z tracking technique*."

In relation to charge 21), the panel found that Mr Bangura demonstrated his lack of competence in delegation as a nurse in charge. It noted that a nurse in charge should be able to demonstrate the organisational skills that are required of a band 5 nurse.

The panel noted that several of the witnesses asserted that Mr Bangura's failings related to a lack of competence rather than misconduct, Witness 7 stated that:

> *"I do not think anything he was doing was malicious or bad in any way. Does that make sense? I do not think he is a bad person or a person of poor character. I just do not think he, at that time when we went through all these processes with him, I do not think at that time he would be, my observations, deemed fit to practise as a nurse. He just did not have the level of skills, the competency or demonstrate the level of skills or competency and understanding to be a first level nurse in old money terms."*

Collectively the panel found that in these areas identified Mr Bangura lacked the key skills that were required of a Band 5 mental health nurse, and that these spanned a significant period from 21 June 2017 until 27 September 2019. The panel considered that the lack of competence here involved an unexpectedly low standard of performance judged by a fair sample of Mr Bangura's work.

The panel therefore found that Mr Bangura's performance in charges 1), 3)a), 4), 6)a), 7)b), 8), 9), 10), 11), 12), 14)b), 16), 17), 18), 19)b) and 21) demonstrated a lack of competence.

Misconduct

The panel noted that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that Mr Bangura's behaviour in charges 22) and 23) was so serious as to amount to misconduct.

In relation to charge 22) Mr Bangura was given a specific task to observe a patient who was actively suicidal for a period of one hour. This risk was consistently handed over on each shift. The panel considered that Mr Bangura allowed Patient B to walk around the ward unobserved, causing her to feel unsafe. This potentially put the patient at serious risk of harm, and this amounted to misconduct.

In relation to charge 23), the panel noted that Mr Bangura's priority should have been patient safety, [PRIVATE]. This patient was vulnerable and aggressive and could have put himself, other patients and the general public at risk of harm. The panel determined that Mr Bangura had a duty of care to his colleagues, Patient C and to the public and he failed in his duty. This panel was of the view that Mr Bangura's actions fell seriously short of the standard of behaviour expected from a band 5 nurse so as to amount to misconduct.

In all the circumstances, the panel determined that Mr Bangura's performance demonstrated a lack of competence and misconduct as identified above.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence and misconduct, Mr Bangura'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. 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> *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 determined that patients were put at risk of harm as a result of Mr Bangura's lack of competence and misconduct. Mr Bangura's lack of competence and misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel noted that the matters found proved were in respect of a number of patients and occurred over a period of nearly three years and therefore were not isolated incidents. The panel also noted that a higher level of support was provided at that time.

It went on to consider whether there is a risk of repetition and in doing so it assessed Mr Bangura's current insight, remorse and remediation. The panel had no evidence before it to demonstrate Mr Bangura's insight or remediation taken. It noted that Mr Bangura had not provided any evidence of reflection or strengthened practice.

In relation to remorse, the panel noted that there was no evidence available to it, including any comments or reflection from Mr Bangura. He has not engaged with this hearing or a meaningful way with the NMC and consequently the panel has not had the benefit of hearing from him.

The panel considered that the lack of competence and misconduct is capable of remediation. However, in this case the panel has received no evidence that Mr Bangura has remedied his practice. Accordingly, it cannot be said that this is highly unlikely to be repeated.

The panel 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 also finds Mr Bangura's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Bangura'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 Bangura'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 Kewley informed the panel that in the Notice of Hearing, dated 6 March 2023, the NMC had advised Mr Bangura that it would seek the imposition of a suspension order with review if it found Mr Bangura's fitness to practise currently impaired.

Mr Kewley submitted that the possible aggravating factors in this case are that the concerns relate to basic and fundamental areas of nursing practice and that there has been a lack of insight, remediation and remorse shown in this case. He submitted that Mr Bangura has had a significant amount of time to develop these but has not done so. Mr Kewley submitted that in relation to mitigation factors, there is no new information regarding Mr Bangura. However, he told the panel that during the previous parts of the hearing it was established Mr Bangura had been practising as a nurse for 17 years.

Mr Kewley submitted that Colleague A confirmed that as far as she was aware there was nothing wrong with Mr Bangura's practice up until the concerns were picked up by his managers at Berkshire Health. He submitted that Mr Bangura was a registrant who had practised for a long time without any regulatory findings but beyond that there is very little that he can draw the panel's attention to.

Mr Kewley submitted that taking no action or imposing a caution order, would not place any restriction on Mr Bangura's practice, and it would not address the public protection concerns and also the risk of repetition that has been identified by the panel. He submitted that in relation to any potential conditions being imposed, there has been no meaningful engagement from Mr Bangura and that there is no evidence of him addressing the concerns. He submitted that the concerns are widespread as they touched different aspects of his practice and that a conditions of practice order would not be sufficient to protect the public. Mr Kewley submitted that a suspension order would protect the public as it would prevent Mr Bangura from practising and a period of suspension would also recognise the panel's findings that these issues in principle are capable of being remediated. The issue is that the concerns have not been remediated.

Mr Kewley submitted that if the panel were to direct there to be a substantive order review hearing towards any period of suspension this would give Mr Bangura an opportunity to reflect what was said by this panel at each of the stages in this case and ultimately to make a decision on his future nursing intentions. He submitted that if the panel is minded to impose a suspension order with a review hearing, the panel may feel that it may be helpful as to what might be expected of him in order to assist the panel members who would be reviewing the order prior to its expiry. On that basis, Mr Kewley submitted that the panel are invited to impose a period of suspension with a review hearing towards the end of that period.

Mr Kewley further submitted that it is the NMC's view that taking into account charges 22) and 23) and its finding of misconduct, the proportionate sanction which reflects the totality of those concerns is that a suspension order protects the public and meets the public interest. He submitted that the NMC does not invite the panel to consider imposing a striking-off order even though it is available to the panel by reason of charges 22) and 23).

Decision and reasons on sanction

Having found Mr Bangura'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:

- Lack of insight into failings despite support over a long period of time; and
- Mr Bangura's lack of competence encompassed a wide spectrum of fundamental nursing practice and took place over a considerable period of time; and
- Misconduct which put patients at risk of suffering harm.

The panel considered any mitigating features however, due to Mr Bangura's lack of engagement the panel found it difficult to identify mitigating features in this case.

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 Bangura'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 Bangura's case 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 Bangura'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:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining; and*
- *Potential and willingness to respond positively to retraining.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the circumstances in this case and Mr Bangura's lack of engagement. The panel noted that Mr Bangura has not engaged with the NMC proceedings, nor does it have any evidence before it to suggest that he will comply with a conditions of practice order if imposed. The panel also noted that despite being subject to a PIP and subsequent capacity programme for almost three years, Mr Bangura's competence had not improved to an acceptable standard. It further noted that it had not seen any evidence before it to demonstrate that he is capable of safe and effective practice. Furthermore, the panel concluded that the placing of conditions on Mr Bangura's registration would not adequately address the seriousness of this case and would not address the public interest issues identified.

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 harmful deep-seated personality or attitudinal problems; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, Mr Bangura's failings were not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate for the misconduct charges and also noted that all the charges in this case with exception to charges 22) and 23) related to lack of competence, the panel concluded that it would be disproportionate. It determined that the misconduct in this case was not so serious as to warrant a striking-off order at this stage.

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 such an order could potentially cause Mr Bangura. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the lack of competence and 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 would be assisted by:

- Mr Bangura's engagement with the NMC and his attendance at the Substantive Order Review Hearing;
- A clear indication of Mr Bangura's future career intentions;
- A reflective statement from Mr Bangura demonstrating his insight into the lack of competence and misconduct;
- Testimonials from any paid or voluntary work; and
- Any evidence of self directed learning or courses attended addressing the lack of competence and or misconduct found in this case.

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 Bangura's own interest until the suspension order sanction takes effect.

Submissions on interim order

The panel considered the submissions made by Mr Kewley that an interim suspension order should be made to cover the appeal period. He submitted that an interim order is necessary for the protection of the public and to protect the wider 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 accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary for the protection of the public and to protect the public interest. The panel had regard to the seriousness of the lack of competence and 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 suspension order would be inconsistent with its earlier findings.

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 suspension order 28 days after Mr Bangura is sent the decision of this hearing in writing.

This will be confirmed to Mr Bangura in writing.

That concludes this determination.