Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 11 August 2025 – Friday 15, August 2025
Monday, 18 August 2025

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

Name of Registrant:	Simelweyinkosi Ngwenya
NMC PIN:	06I1575E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (27 February 2007)
Relevant Location:	Buckinghamshire
Type of case:	Misconduct
Panel members:	Andrew Macnamara (Chair, lay member) Anjana Varshani (Lay member) Rashmika Shah (Registrant member)
Legal Assessor:	Suzanne Palmer (Monday, 11 August 2025 – Friday 15 August 2025) Angus Macpherson (Monday, 18 August 2025)
Hearings Coordinator:	Abigail Addai
Nursing and Midwifery Council:	Represented by Zahra Ahmed, Case Presenter
Mrs Ngwenya:	Not present and unrepresented
Facts proved:	Charges 1(1), 1(2), 2, 3(1)i), 3(1)ii),3(2)i),3(2)ii), 4(a), 4(b)
Facts not proved:	N/A

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 Mrs Ngwenya was not in attendance and that the Notice of Hearing had been sent to her registered email address by secure email on 2 July 2025.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Ngwenya

The panel next considered whether it should proceed in the absence of Mrs Ngwenya. It had regard to Rule 21 and heard the submissions of Ms Ahmed who invited the panel to continue in the absence of Mrs Ngwenya.

Ms Ahmed submitted that Mrs Ngwenya had voluntarily absented herself from the hearing, and that there is a public interest in the expeditious disposal of cases. She submitted that there has been no meaningful engagement from Mrs Ngwenya for some time. The last

direct communication from her was some years ago, and her representative, the Royal College of Nursing (RCN), came off the record on 22 January 2025.

Ms Ahmed submitted that efforts were made to contact Mrs Ngwenya. She submitted that there had been no engagement at all by Mrs Ngwenya with the NMC in relation to this hearing and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mrs Ngwenya. In reaching this decision, the panel has considered the submissions of Ms Ahmed, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Ngwenya;
- Reasonable efforts have been made by the NMC to contact Mrs Ngwenya in advance of this hearing, but she has not engaged with the NMC and has not responded to any of the letters sent to her about the hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 6 witnesses are attending the hearing to give live evidence, and an adjournment may inconvenience those witnesses and their employer(s)
- The charges relate to events that occurred in 2020;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

The panel noted that there is some disadvantage to Mrs Ngwenya in proceeding in her absence. Although the evidence upon which the NMC relies on will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her 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. It has available to it the statement which Mrs Ngwenya provided during the local investigation of these events, and will be able to take that into account when questioning witnesses and assessing their evidence.

Furthermore, the limited disadvantage is the consequence of Mrs Ngwenya's decision to absent herself, from the hearing, waive her right to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair and in the public interest and the interests of justice to proceed in the absence of Mrs Ngwenya. The panel will draw no adverse inference from Mrs Ngwenya's absence when making its findings of fact.

Details of charge

That you, while working as a Band 6 Care in the Community nurse for Buckinghamshire Healthcare NHS Foundation Trust:

1. On one or more of the dates set out in Schedule 1:
(1) incorrectly administered 1 ampoule (10mg) of Midazolam to Resident A, when he was prescribed 2 ampoules (20mg) of Midazolam;
(2) recorded in Resident A's medication administration record that you had administered 20mg Midazolam to Resident A, when you had administered 10mg.

2. On 2 March 2020 removed two ampoules of Midazolam without clinical justification from stock held at 4 Trinity Court Residential Home.

3. On 2 March 2020 incorrectly made one or more of the alterations to entries set out in Schedule 2 in:
(1) 4 Trinity Court Residential Home's Controlled Drug Book for Midazolam and/or in
(2) the Midazolam Stock Record in Patient A's Prescription Record:

(i) when the originally recorded count figures were correct;
(ii) without correctly recording the change(s) you made.

4. Your actions at charge 2 and/or charge 3 (i) were dishonest in that by your actions you deliberately sought to conceal that you had administered 1 ampoule (10mg) of Midazolam to Resident A on one or more of the following dates, when he was prescribed 2 ampoules (20mg) of Midazolam daily:

(a) 29 February 2020
(b) 1 March 2020.

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

Schedule 1

(a) 29 February 2020

(b) 1 March 2020

Schedule 2

(a) Altered the count figure recorded for 29 February 2020 from 17 to 16;
(b) Altered the count figure recorded for 1 March 2020 from 16 to 14.

Background

On 19 November 2020, a referral was made to the NMC by Colleague A, Deputy Chief Nurse Workforce Transformation & Professional Standards, Buckinghamshire Healthcare NHS Trust.

From September 2019 Mrs Ngwenya, having previously worked in a different team at the Trust, was assigned to the Trust's Hospice at Home team as a Band 6 nurse. The team provided nursing care in the community (effectively a district nursing service) to patients requiring End of Life care, including at residential homes which did not have nursing staff. Within the team Mrs Ngwenya had a line manager. The line manager reported to the Matron (Witness 1) who had responsibility for the entire Hospice at Home team.

One of the residential homes for which the Hospice at Home team provided care was 4 Trinity Court ("the Home") which was a 6-bed unit for residents with profound learning disabilities. The residents were cared for by Support Workers (Healthcare Assistants). These included Witnesses 4, 5 and 6. The Home was managed by a Home Manager (Witness 2). In her absence it was managed by various on-call managers, including Witness 3 who was on duty as the on-call manager on 29 February 2020. One of the residents at the Home was Resident A. Resident A had been discharged back to the Home on 26 February 2020, shortly before the events set out in the charges, and was receiving end of life palliative care. He did not have capacity and was unable to communicate verbally. He died at around 11:10 on the morning of 2 March 2020.

Resident A was prescribed a number of medications, which were administered via a syringe driver by a nurse each morning at around 11:00. He arrived at the Home with a supply of these medications when he was discharged from hospital. Resident A's prescribed medication included Midazolam, a Controlled Drug which is a sedative intended to avoid the resident becoming agitated. The prescribed dose was 2 x 10mg ampoules each day (20mg in total). There was also a prescription for PRN ("as required") medication.

The Home had not previously had residents who were prescribed Controlled Drugs but it had procedures in place for the management of Controlled Drugs. One of the members of the care team would hold the key for the Controlled Drugs cupboard on each shift. When a nurse attended from the Hospice at the Home's team, they would go with the keyholder to the staff office to prepare the resident's medication for administration. The nurse and the keyholder would count the stock of the resident's medication together and record the total in the Controlled Drugs book and in the stock record within the resident's Medication Administration Record ("MAR"). They would record the total removed from stock to be administered, and the new total of stock remaining, in the Controlled Drugs book and the stock record within the MAR. The nurse, accompanied by a key holder would take the medication to the resident to administer it, and then record the dose administered on the resident's medication administration record.

In addition to this, the Home kept a second medication count sheet, which was kept by care staff and was not seen by the visiting nurse. Two members of the care staff would count medication three times a day, once in the morning, once in the afternoon and once at night. The checks would take place at around the time of the shift change at approximately 7:00, 15:00 and 22:00.

Mrs Ngwenya was the nurse who visited the Home to administer medication at approximately 11:00 on both 29 February and 1 March 2020. On 29 February 2020 Witness 3, the on-call manager, was the keyholder who counted the medication with Mrs Ngwenya. It is alleged that Mrs Ngwenya took and administered only one ampoule of Midazolam (10mg), despite Witness 3 querying this with her on the basis that 2 ampoules

had been administered the previous day. It is alleged that Mrs Ngwenya and Witness 3 signed the Controlled Drug book and the stock count in the MAR to reflect that 1 ampoule had been used. It is further alleged that Mrs Ngwenya signed the resident's medication administration record indicating that 20mg had been administered.

On 1 March 2020, Witness 6 was the person who was holding the key at the time Mrs Ngwenya attended and who counted the medication with her. It is alleged that, again, Mrs Ngwenya took and administered only 1 ampoule of Midazolam (10mg) and she and Witness 6 signed the Controlled Drug book and stock record in the MAR to reflect that one ampoule had been used. Again, Mrs Ngwenya is alleged to have signed the resident's medication record indicating that 20mg had been administered.

On the night of 1 March 2020 and on the morning of 2 March 2020 (at around 7:00), it is alleged that the Home's separate medication count sheet showed that the number of ampoules of Midazolam remaining (sixteen) tallied with what was recorded in the Controlled Drugs book.

It is alleged that Mrs Ngwenya rang the doorbell of the Home at sometime between 07:00 and 07:30 on 2 March 2020, when she was not on duty and not in uniform, and said that she needed to check 'something' in the medication administration records. Witness 5, who was on duty, went with her to the staff office, opened the Controlled Drug cabinet, and gave Mrs Ngwenya the Controlled Drug book and the medication. Mrs Ngwenya checked these. It is alleged that she made some alterations to the Controlled Drug book but Witness 5 was not able to see what those were. It is alleged that Mrs Ngwenya then asked where the syringe driver was, and went to Resident A's room holding a box of Midazolam. She was only in Resident A's room for a short time. She left the Home shortly afterwards.

It is alleged that the next time the Home's care staff checked the medication, at around 17:00 on 2 March 2020 (by which time Resident A had passed away), Witnesses 2 and 6 identified that 2 ampoules of Midazolam were missing and not accounted for: only fourteen were present, when sixteen had been counted on the night of 1 March 2020 and on the morning of 2 March 2020. On examination, it is alleged that it was found that the

Controlled Drug book had been altered, in that someone had written over the total originally recorded (sixteen) and changed it to fourteen.

The Home reported the matter to Witness 1 who initiated an investigation on behalf of the Trust. Mrs Ngwenya was asked to provide an account, and provided a written statement on 3 March 2020. She was also interviewed by Witness 1. She maintained that she had administered the medication as prescribed on both 29 February and 1 March 2020.

However on 2 March 2020, Mrs Ngwenya said that she returned because she was concerned that she may not have recorded another medication (Buscopan) that she had administered and wanted to check the records. Mrs Ngwenya says that while she was there she counted the other medications and noted that although there were only fourteen ampoules of Midazolam present and the Controlled Drugs book showed sixteen. Mrs Ngwenya says that she therefore altered the total and signed her alteration. She says that she then took boxes of medication with her to Resident A's room in case any PRN medication was required, but it was not. Mrs Ngwenya says that she therefore returned the boxes of medication to the carer and left the Home.

Statements were also provided by members of the Home's staff. The Trust's investigation was never concluded because the matter was reported to the police (the police investigation was ultimately closed with no further action). The missing ampoules of Midazolam were never located. Mrs Ngwenya resigned from her role at the Trust on 19 March 2020.

The NMC's witnesses confirm that Resident A did not appear to suffer any ill-effects from the apparent under-dose of Midazolam on 29 February and 1 March 2020. It could have resulted in increased levels of agitation, but there is no record of Resident A having been agitated on either day.

It is alleged in the charges that Mrs Ngwenya provided the incorrect dose of Midazolam on both days, and made inaccurate entries of what she had administered in Resident A's medication administration record. It is further alleged that on 2 March 2020 she removed two ampoules of Midazolam from stock without clinical justification and incorrectly altered

the recorded stock levels within the MAR and the Controlled Drugs book. It is alleged that the removal of the medication and the alterations to the records were dishonest, in that Mrs Ngwenya was deliberately seeking to conceal that she had administered the wrong dosage on the two previous days.

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 Mrs Ngwenya on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Ngwenya.

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. All roles refer to the witness' roles at the time of the alleged concerns:

- Witness 1: Matron in Palliative and End of Life Care (employed by the Trust);
- Witness 2: Home Manager at the Home.
- Witness 3: On-call Manager at the Home.
- Witness 4: Support Worker at the Home.
- Witness 5: Support Worker at the Home.

- Witness 6: Care Assistant at the Home.

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

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

Charge 1 (1)

> *"1. On one or more of the dates set out in Schedule 1:*
> *(1) incorrectly administered 1 ampoule (10mg) of Midazolam to Resident A, when he was prescribed 2 ampoules (20mg) of Midazolam."*

This charge is found proved.

The panel first took into account the prescription record which showed that Resident A was prescribed 20mg of Midazolam each day. This was corroborated by Witness 1 and 2 in their oral evidence and their witness statements. The panel considered that it was clear from the evidence of Witness 1 that the prescribed dose would require the administration of 2 ampoules. Witness 1 said:

> "*The prescription record… confirms that an ampoule of Midazolam was 10mg in a 2ml injection… Therefore, in order to provide 20mg of Midazolam, the Registrant [Mrs Ngwenya] would need to administer two ampoules".*

The panel next considered whether Mrs Ngwenya incorrectly administered 1 ampoule of Midazolam to Resident A. In doing so, it looked at the description given by Witness 3 in relation to the chronology of events on 29 February 2020, both in her witness statement and in her oral evidence. Witness 3 was the On-call manager and holder of the key to the Controlled Drugs cupboard on that day.

The panel noted from Witness 3's witness statement that on 29 February 2020, she had looked at the "blue folder" (the Resident's file of care notes) and found that Resident A was due to receive Midazolam and had been administered 2 vials the previous day. When Mrs Ngwenya attended to administer the medication, Witness 3 recalled seeing her taking out only 1 ampoule of Midazolam. She said that she queried this with Mrs Ngwenya:

> "*I asked … if she was sure that it was 1 vial of midazolam as Resident A had 2 the day before. Mrs Ngwenya confirmed that it was only 1 vial. I repeated that Resident A had 2 yesterday and Mrs Ngwenya said that it was only 1 for a second time. As I am not a medically trained nurse and I could not see the prescription chart I did not feel it was my place to challenge Mrs Ngwenya again. Mrs Ngwenya was looking at the chart at the time so I trusted that she was administering the correct amount".*

Witness 3 told the panel that she and Mrs Ngwenya then countersigned the Controlled Drug book after counting how much Midazolam was left. Witness 3 also told the panel in her oral evidence and her witness statement that she subsequently (after Mrs Ngwenya had left) raised her concerns about the dose administered with Witness 2.

The panel considered that Witness 3's account was consistent throughout her statement for the local investigation, her witness statement and her oral evidence. It was corroborated by the contemporaneous documents including the MAR stock record and the Controlled Drug book. Witness 2 corroborated Witness 3's account of having raised a concern after Mrs Ngwenya had left the Home. The panel saw nothing to undermine Witness 3's account and considered it to be credible and plausible. The panel accepted her account of events.

In relation to 1 March 2020, the panel then considered the evidence of Witness 6, who was the Support Worker holding the key at the time Mrs Ngwenya attended to administer medication on 1 March 2020. Witness 6 informed the panel that she accompanied Mrs Ngwenya to remove the controlled drug from the cupboard and that Mrs Ngwenya

removed 1 ampoule of Midazolam. Like Witness 3, Witness 6 had countersigned the Controlled Drug Book to show the levels of stock removed and remaining.

The panel also took into account the Controlled Drug Book that column 7 showed -1, suggesting that 1 vial had been given to Resident A and was countersigned by both parties. It also noted that the independent count sheet records a reduction count of 1.

The panel considered that Witness 6's account was consistent throughout her statement for the local investigation, her witness statement and her oral evidence. It was corroborated by the contemporaneous documents including the MAR stock record and the Controlled Drug book. The panel saw nothing to undermine Witness 6's account and considered it to be credible and plausible. The panel accepted her account of events.

The panel concluded that both Witness 3 and Witness 6 had given clear, consistent and detailed evidence of having seen Mrs Ngwenya administer only 1 ampoule of Midazolam on each of the two days referred to in charge 1(1) (29 February and 1 March 2020). In light of this, the panel was satisfied that it was more likely than not that on both the dates set out in Schedule 1, Mrs Ngwenya incorrectly administered 1 ampoule (10mg) of Midazolam to Resident A, instead of the 2 ampoules (20mg) that he was prescribed.

Therefore, on the balance of probabilities, the panel found charge 1(1) proved.

Charge 1 (2)

> *"1. On one or more of the dates set out in Schedule 1:*
>
> *(2) recorded in Resident A's medication administration record that you had administered 20mg Midazolam to Resident A, when you had administered 10mg."*

This charge is found proved.

In reaching this decision, the panel took into account the MAR for Resident A. It noted that there were 2 entries on 29 February 2020 and 1 March 2020, both of which record that she administered 20mg of Midazolam, although (as the panel has found above) Mrs Ngwenya had only in fact administered 10mg (1 ampoule) on each of those days.

The panel also took into account Witness 1's witness statement which reads:

> *'The Registrant (Mrs Ngwenya) was adamant that she had administered the correct dosage but this is not corroborated by the number of ampoules that are recorded as administered in the controlled drug book or the Trust's prescription record'*

The panel found Witness 1's witness statement to be consistent with her oral evidence where she stated '*I asked if she got it mixed up because the paperwork was saying it was 1 amp. We could have dealt with it. The patient did not come to harm'.*

The panel noted that Mrs Ngwenya, during the local investigation, denied having administered the wrong dose, or having made an inaccurate record of what she administered. However, the panel considered that the contemporaneous documentary evidence, coupled with the evidence of Witnesses 3 and 6 discussed in relation to charge 1(1) above, suggested that Mrs Ngwenya was incorrect in her recollection of events. Having found that Mrs Ngwenya had in fact only administered 10mg, it followed logically that what she had recorded having administered (20mg) was incorrect on both days.

The panel was satisfied that it was Mrs Ngwenya who made the relevant entries on the MAR. It noted that she was the only person present at the Home on each of the relevant dates who was qualified to administer the medication. It further noted that when the various Healthcare Assistant witnesses were shown the record of administration within the MAR, none had seen the record before or were able to tell the panel what it means.

The panel therefore considered that it was more likely than not that on both of the dates set out in Schedule 1 (29 February and 1 March 2020), Mrs Ngwenya inaccurately

recorded in Resident A's medication administration record that she had administered 20mg Midazolam to him, when in fact she had administered only 10mg.

Accordingly, the panel found charge 1 (2) proved on the balance of probabilities.

Charge 2

> *"2. On 2 March 2020 removed two ampoules of Midazolam without clinical justification from stock held at 4 Trinity Court Residential Home."*

This charge is found proved.

The panel noted from various witnesses that Mrs Ngwenya was not scheduled to work on 2 March 2020 and arrived at the Home early in the morning (at around 07:30), not dressed in uniform. She told the Support Workers present at the time (Witnesses 4 and 5) that she needed to check "something" in relation to the administration of medication and needed access to the controlled drugs cupboard. Mrs Ngwenya also appeared to be in a hurry and said that her children were in the car outside.

In her own account during the local investigation, Mrs Ngwenya said that she had thought that she might have forgotten to record the administration of a different medication (Buscopan), the previous day, and had gone into the Home to check this and decided to check other medication while she was there. Her account therefore appears to corroborate what the NMC's witnesses said to some extent.

The panel heard from Witness 5 that she was in charge of the controlled drug keys for the shift and had previously (at around 07:00) completed the stock count with a colleague, noting that there was sixteen Midazolam left. The panel found this to be consistent with the Medication Count Sheet which shows that sixteen Midazolam was accounted for in the morning.

Witness 5 said she accompanied Mrs Ngwenya to the Controlled Drugs cupboard and, Mrs Ngwenya requested that Witness 5 take out all the medication, including the Midazolam from the cupboard. She also asked to see the Controlled Drug book Witness 5 said that Mrs Ngwenya kept hold of the Midazolam box and *'checked the CD log book'.* Witness 5 also told the panel that Mrs Ngwenya asked her where the syringe driver was and she was unsure so stepped out of the office to ask Witness 4. This is corroborated by Witness 4's oral evidence and witness statement where she says that Witness 5 came to ask her where the syringe driver was and she informed Witness 5 that it was '*at the top of Resident A's leg'.*

Witness 5 told the panel that she, Mrs Ngwenya and Witness 4 went to Resident A's room and Mrs Ngwenya was still carrying the box of Midazolam. It noted the following from Witness 5's witness statement:

> *'I watched Mrs. Ngwenya move Resident A's blanket and then she held the syringe driver in her hand. At the point, Mrs. Ngwenya still had the box of midazolam in her hand. I did not witness Mrs. Ngwenya administer any medication. I do not believe that Mrs Ngwenya administered any medication… Mrs Ngwenya only held the syringe driver and looked at it. In only a few minutes, Mrs Ngwenya then stated that it was okay and then I did not need to bother coming into Resident A's room as she had finished. Mrs Ngwenya then put the mask she wore with the apron and gloves into the bin and washed her hands in Resident A's sink. Resident A's sink is behind the door'.*

The panel found this to be consistent with Witness 5's oral evidence where she told the panel that Mrs Ngwenya held onto the box of Midazolam throughout their exchange.

Witness 5 said that Mrs Ngwenya checked the Controlled Drug book both before going to Resident A's room and after returning from it. She says that she remembers Mrs Ngwenya amending and writing in the Controlled Drug book, but was not close enough to see exactly

what Mrs Ngwenya was writing. "*However, Mrs Ngwenya had a pen in her hand and was amending the CD log book"*.

The panel then considered the stock discrepancies in the PM count. In doing so, it first had regard to Mrs Ngwenya's response during the local investigation which reads:

> *'When I counted the Midazalam (sic) I noted that there was 14 Amps however when I looked at the controlled drug book the balance stated that there was 17 on the 29.02.20 & a balance of 16 on the 01.03.20'*

Effectively, Mrs Ngwenya's position at the local investigation was that when checking medication on the morning of 2 March 2020 she had discovered that the stock levels of Midazolam did not tally with what was recorded, so she amended the record to reflect what she found to be present.

The panel noted the evidence from the NMC's witnesses that a shortfall in stock was identified during the Home's routine stock check of medication at about 17:00 on 2 March 2020. Witness 5 (who had carried out the 07:00 check with a colleague) described having received a telephone call from Witness 2 after she had returned home following her shift. In her witness statement she said:

> '*I confirmed that we had completed the count. Witness 2 told me that the count was wrong, however, I assured her that I was certain that we had performed the count correctly. I was 100% certain that we had counted the drugs correctly. Witness 2 then told me that the count must be wrong as there were ampoules missing. At this point, I told Witness 2 that there were no missing during the AM count and that the count was correct and then informed her that Mrs. Ngwenya had attended the Home that morning. I told Witness 2 that Mrs. Ngwenya had been holding a box of midazolam in her hand and had arrived early in order to request access to the CD cabinet and CD log book. I told Witness 2 that Mrs. Ngwenya was standing beside Resident A's bed with the box of midazolam.'*

The panel also had sight of the Home's Medication Count Sheet which clearly shows that sixteen vials of Midazolam were counted, both on the night of 1 March 2020 and at around 07:00 on 2 March 2020, and only fourteen vials were counted at 17:30. The count at 07:00 was therefore the same as what was originally recorded in the Controlled Drug book, but at odds with the amended Controlled Drug Book entry.

The panel carefully considered whether or not there was evidence to support the allegation that Mrs Ngwenya removed 2 ampoules of Midazolam. It noted that there was no direct evidence from any witness of having seen her remove any medication. It therefore considered what inferences it could draw about what is likely to have occurred.

The panel considered that there was consistent and credible evidence from a number of the NMC's witnesses, corroborated by documentation at the time, that sixteen ampoules were present in the stock in the Controlled Drug cupboard at around 07:00, and only fourteen were present at around 17:30. It accepted the evidence of Witness 5 about the count she and a colleague carried out in the morning, and the evidence of Witnesses 2 and 6 about the count they carried out in the afternoon.

The panel also noted from Witness 5's oral evidence and witness statement that she was the only one who had access to the cupboard keys until the end of her shift at around 15:00.

The panel noted that, as she was not qualified to administer medication, Witness 5 had no reason to access the controlled drugs cupboard unless she was carrying out a stock check or attending with a nurse who was going to administer medication to Resident A.

Further, the panel heard evidence from various witnesses that Resident A was the only resident at the Home who was given Midazolam. It also heard evidence that Resident A had passed away at around 11:00 on 2 March 2020. Therefore, there would not have been a need to administer Midazolam that day, as Resident A died prior to his medication being administered.

The only other person who accessed the Controlled Drugs cupboard between the 2 medication counts was Mrs Ngwenya, when she attended at around 07:30. Her presence at that time represented the only incident of note in relation to the controlled medication during that shift.

The panel noted that, during her brief attendance at the Home, Mrs Ngwenya had the opportunity to remove or dispose of the medication on a number of occasions, even though she was not directly observed doing so including:

- At the period of time when Mrs Ngwenya was alone in the staff office with the Controlled Drugs cupboard she unlocked the cupboard and the box of Midazolam was in her possession, after Witness 5 had gone out to find out where the syringe driver was;
- Mrs Ngwenya could have placed the ampoules into the sharps box in the office;
- There was a period of time when she was alone in Resident A's room (before Witness 5 had been able to put on PPE and enter), and when she was behind the door of Resident A's room running water in the sink. Witness 5 was clear in her account that she heard the tap running from her position outside the room. It is possible that she may have disposed of the ampoules at that time.

The panel considered that the only logical inference it could draw from the available information was that Mrs Ngwenya had removed 2 ampoules from stock at some point during her visit on the morning of 2 March 2020. It noted that Mrs Ngwenya's account during the local investigation was that she had found that there were only fourteen ampoules when she arrived at the Home on 2 March 2020. However, because of its findings in relation to charge 1, the panel did not find this plausible, and preferred the evidence of Witness 5 (corroborated by the Medication Count Sheet) that there were in fact sixteen ampoules at the checks on the evening of 1 March and at 07:00 on 2 March 2020.

The panel considered that, given its other findings, it was reasonable to infer that when she attended the Home at around 07:30, Mrs Ngwenya may have realised that she had

mistakenly administered and recorded the wrong dose of Midazolam to Resident A on the 2 previous days. That could provide a reason for her making a decision to remove 2 ampoules so that the remaining medication stock tallied with what was recorded as having been administered.

Having concluded that it was more likely than not that Mrs Ngwenya removed the ampoules, the panel concluded that there could have been no clinical justification for doing so. Resident A was not due to receive his next dose of Midazolam until around 11:00 am, and Mrs Ngwenya was not on duty and would not have been scheduled to administer that dose. On her own account, Mrs Ngwenya had already been into Resident A's room as soon as she arrived at the Home, to collect his medication folder, and she would therefore have known that there was no requirement for PRN medication. There was no other plausible clinical justification for the removal and/or disposal of two ampoules of Midazolam that morning.

Accordingly, charge 2 is found proved on the balance of probabilities.

Charge 3 (1)i) and Charge 3(1)ii)

> *"3. On 2 March 2020 incorrectly made one or more of the alterations to entries set out in Schedule 2 in (1) 4 Trinity Court Residential Home's Controlled Drug Book for Midazolam.*
>
> *(i) when the originally recorded count figures were correct;*
>
> (ii) without correctly recording the change(s) you made."

This charge is found proved.

The panel noted from Witness 5's evidence that Mrs Ngwenya had been left in the office alone, and had sufficient time to amend the record. Further, it took into account that Witness 5 saw Mrs Ngwenya making alterations to the record. In her live evidence Witness 5 said

that she saw Mrs Ngwenya '*doing something with a pen'*. This was corroborated by Witness 5's witness statement which reads:

> *'I can remember Mrs. Ngwenya amending and writing in the CD log book on 2 March 2020. I was not close enough to see exactly what Mrs. Ngwenya was amending. However, Mrs. Ngwenya had a pen in her hand and was amending the CD log book.'*

The panel also found Witness 5's evidence to be consistent with the entries in Controlled Drugs book for 29 February and 2 March 2020. It noted that both dates had -1 in the column entitled "amount supplied" and the amendment from seventeen to sixteen (29 February 2020) and from sixteen to fourteen (1 March 2020) in the column named 'balance left in stock'. Further, the panel took into account the stock record in Resident A's MAR had the same amendment which was signed and dated by Mrs Ngwenya for the respective dates.

The panel next considered Mrs Ngwenya's local statement which stated the following:

> *'I altered the balance on the controlled drugs book to read 16 on the 29.02.20 & balance of 16 on the 01.03.20 and signed my alteration'*

The panel also took into account Witness 1's oral evidence and witness statement where she outlines the appropriate measures that staff should do when noting an error, including striking the error and making a record of the correct action. The panel found Witness 1's evidence to be consistent with the Controlled Drug Standard Operating Procedure – Procedure for Administration of Controlled Drugs, specifically the following:

> *'A medication error shall be reported on the Trust's Datix system by the individual involved in making or detecting the error'*

> *'Any loss of medicines shall be reported immediately to the duty Senior Manager who will inform the Director of Pharmacy and the Chief Nurse and reported on Datix'*

The panel noted from Witness 1 that Mrs Ngwenya was an experienced nurse and had been aware of this policy from her induction. The panel considered that if, as she asserted, Mrs Ngwenya had identified that there was an incorrect record of medication, or a discrepancy between what was there or what should be there, there were a number of steps she should have taken to record those matters properly. Those would include identifying and explaining the amendments she had made, getting someone else to check and countersign the amended figure, and informing her line manager or the Home's manager of the discrepancy. A discrepancy in levels of a controlled drug, which was a powerful sedative, was a potentially serious matter which could raise issues of concern about inadvertent overdosing of a resident. This would require escalation. However Mrs Ngwenya did not take any of those steps and simply crossed out the stock count and entering a new figure with no explanation. The panel considered that this undermined Mrs Ngwenya's account of what happened.

For essentially the same reasons as in relation to charge 2, the panel considered that the only logical inference it could draw in the circumstances was that Mrs Ngwenya had made amendments to both the Controlled Drug book and the Midazolam stock record in Resident A's MAR. In both cases, for reasons set out in relation to charge 2, the panel was satisfied on the balance of probabilities that the amendment did not accurately reflect the balance of stock of Midazolam which was in fact present on the morning of 2 March 2020. Instead, it reflected the stock level which would have been present if Mrs Ngwenya had administered the correct dose to Resident A on 29 February and 1 March 2020.

Therefore, on the balance of probabilities, the panel found charge 3 (1)i) and charge 3(1)ii) proved in its entirety.

Charge 3(2)i) and Charge 3(2)ii)

> *"3. On 2 March 2020 incorrectly made one or more of the alterations to entries set out in Schedule 2 and/or in (2) the Midazolam Stock Record in Patient A's Prescription Record:*
>
> *(i) when the originally recorded count figures were correct;*

(ii) without correctly recording the change(s) you made."

This charge is found proved.

Having considered all the evidence in the round and noting its findings in relation charge 3 (1)i) and charge 3(1)ii), the panel was satisfied that that it was more likely than not that Mrs Ngwenya had altered Resident A's Stock Record in his Prescription Record and altered the Home's Controlled Drug Book without correctly recording the changes she made. The panel determined that there was no clinical justification for Mrs Ngwenya's visit to the Home on 2 March 2020 or to make the amendments she did. Mrs Ngwenya did not follow the correct procedure when making her amendments. It appeared likely that she made them in an attempt to conceal her earlier mistake in relation to the administration of medication.

Therefore, on the balance of probabilities, the panel found charge 3(2)i) and charge 3(2)ii) proved in its entirety.

Charge 4(a) and Charge 4(b)

"4. Your actions at charge 2 and/or charge 3 (i) were dishonest in that by your actions you deliberately sought to conceal that you had administered 1 ampoule (10mg) of Midazolam to Resident A on one or more of the following dates, when he was prescribed 2 ampoules (20mg) of Midazolam daily:

(a) 29 February 2020

(b) 1 March 2020."

This charge is found proved.

In reaching its decision, the panel referred to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, paragraph 74:

‘When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual’s knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest.’

The panel first considered Mrs Ngwenya’s state of mind in respect of the incidents at charge 2 (removal of two ampoules of Midazolam) and 3(i) (amendment of stock count figures when the original figures were correct and the amendment was incorrect).

The panel had regard to its findings in relation to both charges. As set out there, the panel considered it significant that Mrs Ngwenya came into the Home whilst she was off duty and gained access to the medication cupboard and controlled drugs book. She had removed medication and made amendments to reflect the count after the removal of that medication, without following proper procedure in terms of explaining or escalating any discrepancy. There was no clinical justification for her actions. The most likely explanation, and the only reasonable inference the panel considered it could draw in the circumstances, was that Mrs Ngwenya had realised that she had made a mistake on 29 February and 1 March 2020 in relation to the dosage of Midazolam, and was seeking to conceal that earlier mistake by adjusting the actual and recorded levels of Midazolam stock to reflect what it would have been if she had administered the correct amount.

The panel therefore considered that Mrs Ngwenya’s actions were deliberate and intentional, and done in order to conceal her own mistake, even though she was aware of the correct procedures in relation to medication errors or discrepancies. The panel concluded that Mrs Ngwenya’s state of mind was therefore dishonest. It considered that if

the member of public was informed of the evidence of this case, they would deem her actions as dishonest.

Accordingly, the panel found charge 4 proved in relation to both charge 2 and charge 3(i).

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mrs Ngwenya'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 ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Second, and only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Ngwenya's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Ahmed invited the panel to take the view that the facts found proved are serious and amount to misconduct. Ms Ahmed referred the panel to parts of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) which she submitted were engaged in this case.

Ms Ahmed submitted that Mrs Ngwenya's conduct breached standard 10 of the Code because Mrs Ngwenya's retrospective entries undermined the integrity of the audit trail of the records. Ms Ahmed further submitted that Mrs Ngwenya's conduct breached standard 14, specifically 14, 14.1, 14.2 and 14.3. She submitted while there was no evidence of harm caused to Resident A as a result of the underdose, Mrs Ngwenya was required to be candid and failed to act with candour. Ms Ahmed further submitted that Mrs Ngwenya did not escalate the error appropriately, even when Witness 1 queried the correct dosage. Instead, Mrs Ngwenya hindered local investigation by representing that there had been no mistake and stating that the retrospective entries were accurate.

Ms Ahmed also submitted that standards 19.1, 20, 20.2, 20.6 were engaged. She submitted that the panel heard evidence from Witness 1 that if Mrs Ngwenya's conduct in administering the wrong dose was a mistake, it could easily have been rectified.

Ms Ahmed submitted that the panel heard evidence that at the Home a number of unqualified staff relied on the nurse attending to administer controlled drugs for their expertise. Given the panel's findings of fact, Ms Ahmed submitted that Mrs Ngwenya breached the trust placed on her by Resident A, staff and those who assisted her. Therefore, Ms Ahmed submitted that charges found proved were sufficiently serious to amount to misconduct.

Submissions on impairment

Ms Ahmed moved on to the issue of impairment and addressed the panel on the need to protect the public and also to have regard to the wider public interest considerations. These included the need to declare and uphold professional standards and maintain

public confidence in the profession and in the NMC as a regulatory body. Ms Ahmed made reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Ahmed submitted that all 4 limbs of the *Grant* test are engaged in this case, and therefore that Mrs Ngwenya's misconduct impairs her current fitness to practice. Ms Ahmed submitted that Mrs Ngwenya acted dishonestly by removing medication and falsifying records, which raised serious questions about her trustworthiness as a professional.

Ms Ahmed submitted that Mrs Ngwenya has not demonstrated insight or remediation, provided evidence of reflection, responded to the NMC or provided any information apart from a local statement in 2020. Ms Ahmed therefore submitted that there is no evidence that Mrs Ngwenya would not act in a similar manner again.

In light of this, Ms Ahmed submitted that there is a risk of future repetition and risk of harm to patients. She submitted that Mrs Ngwenya did not think about the potential harm this may have caused to Resident A. Therefore, Mrs Ngwenya's conduct puts patients at risk of harm and engages the need to take regulatory action to support public confidence and professional standards.

Ms Ahmed submitted that each proven allegation individually constitutes misconduct, and that a finding of impairment is warranted on the grounds of public protection and is also in the wider public interest.

The panel accepted the advice of the legal assessor in relation to both misconduct and impairment, which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *R (Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin), *R (Calhaem) v GMC* [2007] EWHC 2606 (Admin), *Johnson & Maggs v NMC (No. 2)* [2013] EWHC 2140 (Admin), *Cohen v GMC* [2008] EWHC 581 (Admin), *CHRE v NMC*

& Grant [2011] EWHC 927 (Admin), *Schodlok v GMC* [2015] EWCA Civ 769, *Kimmance v GDC* [2016] EWHC 1808 (Admin), and *Lusinga v NMC* [2017] EWHC 1458 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Ngwenya's actions amounted to a breach of the Code. Specifically, the panel considered that the following provisions of the Code were engaged:

*'**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:

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

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

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

To achieve this, you must:

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

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

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

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

20.2 act with honesty and integrity at all times,…

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

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

The panel considered whether each of the individual charges amounted to a sufficiently serious departure from professional standards to amount to misconduct.

Charge 1(1) and Charge 1(2)

The panel was of the view that sections 10.3, 18.2 and 19.1 of the Code are engaged in respect of charge 1. The panel noted that on 2 consecutive days, Mrs Ngwenya had administered an incorrect dose of Midazolam to Resident A, by administering only 1 ampoule instead of the 2 prescribed, and had recorded that the full prescribed dose was administered. The panel acknowledged that this potentially represented poor medications practice, in terms of a failure to check the dose and identify that it was incorrect prior to administration. It was an aggravating feature that the mistake took place on 2 consecutive days, and that on the first of those days the Support Worker who was present with Mrs Ngwenya had specifically queried whether the dosage was correct, pointing out that 2 ampoules had been administered the previous day.

However, the panel considered that there was no evidence that this was anything other than a genuine error in the administration of medication, and it was isolated in the sense that it involved a single medication and a single patient, within a short space of time. The panel was mindful that isolated clinical errors, even those which amount to negligence, will not generally represent a sufficiently serious departure from standards to amount to misconduct unless they are particularly grave. The panel noted that while an underdose of Midazolam had the potential to lead to increased agitation, there was no evidence of actual harm to Resident A in this case. The panel noted the evidence of Witness 1 that, had Mrs Ngwenya acknowledged her mistake, the matter could readily have been dealt with at local level.

Viewing matters in the round, the panel considered that although the failures identified by charge 1 represented poor medication practice and poor judgment, and were potentially negligent or incompetent, they were not sufficiently serious to be characterised as “deplorable” or to amount to misconduct in all the circumstances.

The panel therefore determined that the proven actions in charge 1 did not amount to misconduct.

Charge 2

The panel determined that sections 14, 14.1, 14.2, 14.3, 20 and 20.1 of the Code are engaged by the proven conduct in relation to this charge. The panel was mindful of its previous finding that it was likely that Mrs Ngwenya had identified on 2 March 2020 that she had made a mistake in the dosage of Midazolam she had administered on the two previous days. Her actions in relation to charges 2 and 3 related to how she dealt with the mistake she identified, and the panel considered her actions in this regard to be significantly more serious than the original clinical mistake.

The panel heard evidence that Resident A was taking Midazolam to prevent him from becoming agitated. Despite no actual harm being caused to Resident A, the panel considered that Mrs Ngwenya should have been alive to the possibility that it could have caused him harm. By removing the ampoules, Mrs Ngwenya concealed the fact that there had been an underdose and undermined the integrity of the audit trail in Resident A's records. This could have resulted in problems in ongoing care, for example if Resident A had become agitated, staff might have felt unable to administer further medication because they would have believed that the prescribed dose had already been given. Neither the administration record nor the stock count would have given the true picture of the care Mrs Ngwenya had provided.

In addition, the panel noted that Resident A was the only resident at the Home who was receiving Midazolam at the home. The stock of medication with which he had been discharged from hospital was for his exclusive use and, by removing 2 ampoules from that stock, those ampoules were no longer available for use when he might have needed them.

The panel bore in mind Witness 1's evidence that Mrs Ngwenya had been trained on the appropriate measures to take when a drug error had occurred. She should have recorded her mistake clearly in the Controlled Drug book and/or medication administration record, and escalated it so that other staff were aware of the underdose. Instead, the panel had found at the facts stage that Mrs Ngwenya was acting dishonestly, deliberately seeking to conceal the mistake she had made. This was contrary to the duty of candour set out in

section 14 of the Code. There was no clinical justification for her actions, instead they were done to prevent detection of a mistake she had made. This was a breach of the trust placed in her to act professionally and in the best interests of her patients.

The panel considered that this incident represented a serious departure from professional standards and would be regarded by fellow professionals as deplorable. It concluded that the proven actions in relation to charge 2 were sufficiently serious to amount to misconduct.

Charge 3(1)(i) & (ii) and Charge 3(2)(i) & (ii)

The panel decided to consider the various sub-charges of charge 3 together because they arose from the same incident.

The panel considered that sections 10.2, 10.3, 14, 14.1, 14.2 and 14.3 of the Code are engaged by the proven conduct in this charge. As with charge 2, the panel considered that Mrs Ngwenya's actions in relation to charge 3 related to how she dealt with the mistake she identified in relation to her previous administration of medication, and the panel considered her actions in this regard to be significantly more serious than the original clinical mistake.

By falsifying records to try and cover her mistake, Mrs Ngwenya concealed the fact that there had been an underdose and undermined the integrity of the audit trail in Resident A's records. As set out in the panel's decision in respect of charge 2 above, this could have resulted in problems in ongoing care. The panel considered that these actions went well beyond simply poor professional judgment, because they involved deliberate and dishonest amendment of records to provide misleading information about what had happened, despite the fact that Mrs Ngwenya knew the action she was supposed to take in respect of an identified mistake.

The panel considered that the proven actions in charge 3 would be regarded as "deplorable" by fellow professionals and fell significantly short of expected professional standards. It concluded that the matters found proven in relation to charge 3 were sufficiently serious to amount to misconduct.

Charge 4(a) and 4(b)

The panel decided to consider the charges together because the two instances of dishonesty (removal of the ampoules and recording of incorrect count of Midazolam) were inextricably linked and part and parcel of the same act of concealment.

The panel noted its earlier finding that Mrs Ngwenya's actions were done deliberately in order to conceal her clinical mistake. This was a breach of the trust placed in her to act professionally and in the best interests of her patients. Rather than act with the candour required of her by the Code in order to put matters right, she had put her own interests first. The panel considered that Mrs Ngwenya's actions went to the heart of what patients and colleagues expect of a professional nurse: honesty, candour and trustworthiness. The panel considered that this conduct would be regarded as "deplorable" by fellow members of the profession and represented a significant departure from the professional standards required of a registered nurse. It concluded that the dishonesty found proved in charge 4 was sufficiently serious to amount to misconduct.

Viewing the charges in the round, the panel acknowledged that mistakes can occur within a nurse's clinical practice, hence its finding in relation to charge 1 that the clinical error itself did not amount to misconduct in the circumstances. However, the panel was of the view that once a mistake has been identified it is important to be open and candid about what has happened and to take the appropriate steps to put matters right, to ensure that safe treatment can continue to be provided to the patient. The way in which Mrs Ngwenya dealt with the mistake, by deliberately and dishonestly seeking to cover it up with the actions described in charges 2 and 3, viewed both individually and collectively, were a serious departure from professional standards and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide whether, as a result of her misconduct in charges 2, 3 and 4, Mrs Ngwenya's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

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

The panel determined that all 4 limbs of *Grant* case are engaged in this case by Mrs Ngwenya's past misconduct. The panel finds that Resident A was put at some risk of harm as a result of Mrs Ngwenya's misconduct, in that her actions had the potential to impact on continuity of care, and further medication might have been withheld because the underdose was concealed. Mrs Ngwenya's misconduct breached the fundamental tenets of the nursing profession to act with trustworthiness and candour, and therefore brought its reputation into disrepute. The panel considered that confidence in the nursing profession

would be undermined if its regulator did not find the charges relating to dishonesty extremely serious.

The panel next considered whether Mrs Ngwenya was liable, or likely, to act in such a way again in future. This involved an assessment of the risk of repetition, which in turn required the panel to consider factors such as whether there is evidence that past failings have been addressed, and the levels of reflection and insight demonstrated by Mrs Ngwenya.

The panel was mindful that the incidents occurred 5 years ago. The only information which has ever been provided by Mrs Ngwenya since that time is her statement for the local investigation, provided shortly after the events. The panel considered that that statement did not demonstrate any meaningful evidence of remorse, reflection or insight into what went wrong. Mrs Ngwenya did not accept that she had made a clinical error at that time.

Since that time, no further information or evidence has been provided by Mrs Ngwenya and nothing is known about her current situation or future intentions with regard to her nursing career. In February 2022, her then representatives indicated that Mrs Ngwenya had not worked as a nurse since the referral to the NMC (having resigned from the Trust in March 2020). Mrs Ngwenya's representatives also came off the record in January 2025. No other information or response to the charges has ever been provided to the NMC.

As a consequence, the panel had no evidence before it of any development in the level of Mrs Ngwenya's insight in relation to these events in the 5 years since they occurred. There is no evidence to demonstrate remorse, reflection, training or strengthening of her practice, or to demonstrate any lessons learned from these events. Neither is there any evidence of safe clinical practice since these events occurred.

In the absence of evidence of accountability, insight and strengthening of practice, the panel could not be satisfied that Mrs Ngwenya is currently capable of practising, safely, kindly and professionally. It concluded that there remains a risk of repetition of similar conduct in future. The panel was mindful that, although the original clinical errors were

readily remediable, the way in which Mrs Ngwenya subsequently sought deliberately to conceal her errors, putting her own interests before those of her patients and colleagues, was attitudinal in nature. Whilst Mrs Ngwenya's conduct is theoretically capable of being remedied through reflection and insight, there was no evidence that any remedial action had been taken by Mrs Ngwenya. If Mrs Ngwenya were to repeat her actions, there would be potential for patient harm associated with the concealment of mistakes and falsification of records, including the potential impact on continuity of care.

The panel therefore concluded on public protection grounds that Mrs Ngwenya's fitness to practise is currently impaired.

The panel next considered the wider public interest considerations. These include promoting and maintaining public confidence in the nursing professions and upholding the proper professional standards.

The panel determined that a finding of impairment on public interest grounds is also required in this case. It bore in mind that nurses are in a position of trust and are expected by colleagues and patients to be open and candid when they make a mistake. Mrs Ngwenya's dishonesty, by taking deliberate steps to conceal her mistake in breach of policy and of the duty of candour, raises attitudinal concerns about her levels of professionalism. This has the potential to undermine the confidence patients and members of the public place in the profession. There is currently no evidence that those attitudinal concerns have been addressed, or that Mrs Ngwenya has learned anything from these events. The panel considered that public confidence in the profession and the regulatory process would be undermined if Mrs Ngwenya were permitted to practise unrestricted at this time. It therefore concluded on wider public interest grounds that Mrs Ngwenya's fitness to practise is currently impaired.

Having regard to all of the above, the panel was satisfied that Mrs Ngwenya's fitness to practise is currently impaired on both public protection and wider public interest grounds.

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 Mrs Ngwenya's registration has been suspended.

Submissions on sanction

Ms Ahmed informed the panel that in the Notice of Hearing, dated 2 July 2025, the NMC had advised Mrs Ngwenya that it would seek the imposition of a striking-off order if it found Mrs Ngwenya's fitness to practise currently impaired.

Ms Ahmed referred the panel to NMC Guidance: Sanctions for particularly serious cases (reference: San-2), namely the section entitled 'Cases involving dishonesty'. Further, she submitted that Mrs Ngwenya breached the duty of candour and this is harder to put right. She submitted that there are concerns about Mrs Ngwenya's trustworthiness as a nurse.

Ms Ahmed submitted that the following aggravating features are present in this case:

- The dishonesty found proved related to deliberately removing a controlled drug and falsifying records.
- Mrs Ngwenya was responsible for administering a controlled drug to a vulnerable resident.
- Mrs Ngwenya did not act candidly and placed her own interest above patient safety.
- The context around the dishonesty raises serious questions about Mrs Ngwenya's professionalism.
- Attitudinal concerns.
- Mrs Ngwenya has not engaged since 2020, nor provided any evidence of insight, remediation, strengthening practise, nor of any training or reflection.

- Mrs Ngwenya's conduct put patients at potential risk of harm.

Ms Ahmed further submitted the following mitigating factors are present this case:

- The initial clinical error did not cause harm to Resident A although the subsequent dishonesty raises concerns.
- The incident was isolated to the two dates.
- The regulatory concerns are against a backdrop of an unblemished career.
- The allegations occurred in 2020.

Ms Ahmed submitted that the only appropriate and proportionate sanction is a striking-off order given the context of the dishonesty. Ms Ahmed referred the panel to its finding on impairment and submitted there is no evidence of insight, remediation and reflection. Therefore, there is a risk of repetition.

Ms Ahmed submitted Mrs Ngwenya's dishonesty is fundamentally incompatible with her remaining on the register. For this reason, Ms Ahmed invited the panel to impose a striking-off order to protect the public and maintain and uphold proper professional standards of the nursing profession.

The panel accepted advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Ngwenya'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 Sanctions Guidance (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:

- A deliberate cover up of a clinical mistake.
- Midazolam is a controlled drug.
- Resident A was receiving End Of Life Care.
- The context of the dishonesty because Care Workers put their trust in Mrs Ngwenya; she was the only medical professional present at the time.
- No expression of remorse.
- Lack of insight into failings.
- Lack of remediation, training, engagement and reflection.
- Conduct which put patients at potential risk of suffering harm.

The panel also took into account the following mitigating features:

- Resident A suffered no harm as a result of Mrs Ngwenya's conduct.
- The incident was isolated to the two days identified in Schedule 1.

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

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 Mrs Ngwenya's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Ngwenya's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether imposing conditions of practice on Mrs Ngwenya's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable.
The panel took into account the SG in respect of conditions of practice

The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel reflected that the misconduct relates to Mrs Ngwenya's dishonesty and integrity not her clinical practice. It noted that Mrs Ngwenya has not engaged with the NMC since 2020 and as a result, the panel do not have evidence that she is currently working as a nurse.

The panel concluded that the placing of conditions on Mrs Ngwenya's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*

The panel recognises that this is a very serious case which involved the taking of Midazolam without clinical justification and falsifying records in an attempt to conceal a mistake. However, the panel was of the view that this was an isolated incident which occurred across two days. There was no evidence that Mrs Ngwenya has ever engaged in this conduct before or since the events in question.

The panel took into account all the evidence before it and concluded that Mrs Ngwenya's misconduct should be properly understood as an act of panic rather than representing deep seated attitudinal concerns. In light of this, the panel was satisfied that in this case,

the misconduct is not fundamentally incompatible with Mrs Ngwenya remaining on the register.

The panel carefully considered whether a striking-off order would be the only proportionate sanction but taking into account of all the information before it, the panel concluded that this is not the case. Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive in Mrs Ngwenya's case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause Mrs Ngwenya. However this is outweighed by the public interest in this case.

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

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

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

Any future panel reviewing this case would be assisted by:

- Mrs Ngwenya's attendance and engagement in these proceedings.

- A written piece setting out Mrs Ngwenya's reflections as to why she behaved as she did, and what Mrs Ngwenya has learnt subsequently. The reflective piece should include:
    - Mrs Ngwenya's understanding of the importance of taking the correct and appropriate action following any clinical or medication administration errors.
    - An account of how dishonesty can affect public confidence and trust in the nursing profession.

- Evidence of any training which Mrs Ngwenya has undertaken to show how she has addressed her shortcomings including medication administration training that demonstrate that she is able to practise kindly, safely and professionally.
- References and testimonials in respect of any paid or unpaid work.
- Mrs Ngwenya's future intentions regarding her nursing practice.

This will be confirmed to Mrs Ngwenya in writing.

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 Mrs Ngwenya's own interests until the suspension order takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Ahmed. She invited the panel to impose an interim suspension order for a period of 18 months. She submitted that this will

cover the 28 days before the final suspension order would take effect, and the appeal period should an appeal be lodged.

Decision and reasons on interim order

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

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

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

That concludes this determination.