Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
10-12 and 15-18 December 2025

Virtual Hearing

Name of Registrant:	Ijeoma Benedette Uche
NMC PIN:	00Y0222O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 25 October 2000
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Anica Alvarez Nishio (Chair – Lay member) Deborah Bennion (Registrant member) Sam Wade (Lay member)
Legal Assessor:	Simon Walsh
Hearings Coordinator:	Vicky Green
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Ms Uche:	Not present and not represented in her absence
Facts proved:	Charges 1.5, 2.2, 3, 4.1
Facts not proved:	Charges 1.1, 1.2, 1.3, 1.4,1.6, 2.1, 4.2, 5.1, 5.2, 5.3, 6.1, 6.2 and 6.3
Fitness to practise:	Currently impaired
Sanction:	**Conditions of practice order – 6 months**
Interim order:	**Interim conditions of practice order – 18 months**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Uche was not in attendance and that the Notice of Hearing letter (the Notice) had been sent to her registered email address by secure email on 11 November 2025.

Mr Edwards, 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 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 Ms Uche'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 Ms Uche has been served with the Notice, in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Uche

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

Mr Edwards drew the panel's attention to the Proceeding in absence bundle which included a number of emails from Ms Uche to the NMC. Mr Edwards submitted that Ms Uche appears to have disengaged after sending an email to the NMC on 19 November 2025.

Mr Edwards submitted that the NMC has made numerous attempts to secure a response from Ms Uche about whether she intended to attend this hearing. He referred

the panel to the communication log contained within the proceeding in absence bundle and informed the panel that the NMC did not receive a response from Ms Uche about whether she would like to attend this hearing and if not, whether she was content for it to proceed in her absence.

Mr Edwards submitted that Ms Uche appears to have disengaged with these proceedings and that she has voluntarily absented herself. He submitted that Ms Uche is aware of the NMC proceedings and the Notice was sent to the email address that she had used for recent communications. Mr Edwards submitted that Ms Uche has not requested an adjournment, and that there is no guarantee that an adjournment would secure her attendance in the future. He submitted that witnesses have been warned to give evidence and they have taken time out of their schedules to do so.

Mr Edwards submitted that it is in the public interest to proceed in the absence of Ms Uche. He submitted that the allegations are serious, and any potential adjournment would mean that these matters are not heard for a considerable amount of time. Mr Edwards also submitted that delaying this matter further may not be in Ms Uche's interests.

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* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Ms Uche. In reaching this decision, the panel considered the submissions of Mr Edwards and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- The panel noted Ms Uche's detailed email to the NMC dated 18 November 2025 which gave conflicting information as to whether she wanted to continue to engage with these proceedings.
- The panel also noted Ms Uche's email to the NMC dated 19 November 2025 in which she said '*I will restrict NMC for a moment'*.
- Ms Uche had not responded to subsequent email communications and telephone calls to two different numbers made by the NMC.
- No application for an adjournment has been made by Ms Uche.
- There is no information to indicate that adjourning this hearing would secure Ms Uche's attendance in the future.
- Witnesses have made themselves available to give evidence at this hearing and not proceeding may inconvenience the witnesses and their employer(s).
- The charges relate to events that occurred in 2023 and further delay may have an adverse effect on the ability of witnesses accurately to recall events.
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Uche in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence. 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 Ms Uche's decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided to proceed in the absence of Ms Uche. The panel will draw no adverse inference from Ms Uche's absence in its findings of fact.

Details of charge (as read)

That you a registered nurse whilst employed at Primelife / Tanworth Court (the 'Home'):

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.1 That Resident A was weight bearing when they were not.
1.2 That Resident A did not have a history of falls when they did.
1.3 That Resident A was a medium risk of falls when they were a high risk of falls.
1.4 That Resident A required a normal mattress when they required an airflow mattress.
1.5 Referred to Resident C instead of Resident A.
1.6 That the gap of bed edge was 6 metres when it was 6mm.

2. Having documented incorrect information in Resident A's risk assessment and/or plan of care, as set out in charge 1, sent such documentation to a safeguarding officer at the local authority:

2.1 On 26 June 2023.
2.2 On 28 June 2023.

3. On or around 27 June 2023, failed to recognise that:

3.1 That thickener was a prescribed medication.
3.2 That thickener prescribed for one resident could not be administered to another resident.

4. On or around 27 June 2023;

4.1 Sought to undertake a medication round when you had not completed a medication competency using the Primelife format.
4.2 Sought to *'run medications'* that was prohibited by the Home.

5. On or around 28 June 2023, having suspected that Resident B had an adverse reaction to their medication, failed to:

5.1 Check and/or ensure that Resident B's vital signs were taken.
5.2 Call and/or ensure that 111 / GP was called for advice.
5.3 Consider and/or ensure that a referral to the Tissue Viability Nurse was made.

6. Between 23 June 2023 and 30 June 2023, on one or more occasions, created and/or completed residents care plans:

6.1 Before the resident had arrived at the Home.
6.2 Without attending and/or assessing the resident.
6.3 Using previous data contained in the care plan that is not up to date.

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

Decision and reasons on application to amend charge 1.6

Mr Edwards made an application to amend the wording of charge 1.6 pursuant to Rule 28 of the Rules.

Charge 1.6 currently reads as follows:

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.6 That the gap of bed edge was 6 metres when it was 6mm.

The proposed amendment to charge 1.6 is as follows:

1. On or around 26 June 2023 documented the following inaccurate information in

Resident A's risk assessment and/or plan of care:

1.6 That the gap of the bed edge was 6 metres. ~~when it was 6mm~~.

Mr Edwards submitted that the proposed amendment would better reflect the evidence.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that the amendment, as proposed, did not provide any clarity and did not make sense. It therefore decided to reject the application as it was not in the interests of justice to change a charge which was unclear, to another which was also unclear.

Decision and reasons on consideration of amending charge 3

Before the panel had made any findings on the facts, of its own volition, it invited submissions from the NMC on the proposed amendment to charge 3.

Charge 3 currently reads as follows:

3. On or around 27 June 2023, failed to recognise that:

3.1 That thickener was a prescribed medication.
3.2 That thickener prescribed for one resident could not be administered to another resident.

The proposed amendment to charge 3 is as follows:

3. On or around 27 June 2023, failed to recognise ~~that :3.1 That thickener was a prescribed medication. 3.2 T~~ that thickener prescribed for one resident could not be ~~administered to~~ used for another resident.

Mr Edwards opposed this application. He submitted that the proposed amendment does not cover charge 3.1 adequately.

The panel accepted the advice of the legal assessor.

The panel had regard to the submissions of Mr Edwards on behalf of the NMC, however, it decided to proceed with the proposed amendment as it was of the view that it would better encapsulate the underlying seriousness of the charge, and it would be in the interests of justice.

Charge 3 now reads as follows:

3. On or around 27 June 2023, failed to recognise that thickener prescribed for one resident could not be used for another resident.

Details of charge (as amended)

That you a registered nurse whilst employed at Primelife / Tanworth Court (the 'Home'):

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.1 That Resident A was weight bearing when they were not. **[Not proved]**
1.2 That Resident A did not have a history of falls when they did. **[Not proved]**
1.3 That Resident A was a medium risk of falls when they were a high risk of falls. **[Not proved]**
1.4 That Resident A required a normal mattress when they required an airflow mattress. **[Not proved]**

1.5 Referred to Resident C instead of Resident A. **[Proved]**
1.6 That the gap of bed edge was 6 metres when it was 6mm. **[Not proved]**

2. Having documented incorrect information in Resident A's risk assessment and/or plan of care, as set out in charge 1, sent such documentation to a safeguarding officer at the local authority:

2.1 On 26 June 2023. **[Not proved]**
2.2 On 28 June 2023. **[Proved in respect of charge 1.5]**

3. On or around 27 June 2023, failed to recognise that thickener prescribed for one resident could not be used for another resident. **[Proved]**

4. On or around 27 June 2023;

4.1 Sought to undertake a medication round when you had not completed a medication competency using the Primelife format. **[Proved]**
4.2 Sought to *'run medications'* that was prohibited by the Home. **[Not proved]**

5. On or around 28 June 2023, having suspected that Resident B had an adverse reaction to their medication, failed to:

5.1 Check and/or ensure that Resident B's vital signs were taken. **[Not proved]**
5.2 Call and/or ensure that 111 / GP was called for advice. **[Not proved]**
5.3 Consider and/or ensure that a referral to the Tissue Viability Nurse was made. **[Not proved]**

6. Between 23 June 2023 and 30 June 2023, on one or more occasions, created and/or completed residents care plans:

6.1 Before the resident had arrived at the Home. **[Not proved]**
6.2 Without attending and/or assessing the resident. **[Not proved]**
6.3 Using previous data contained in the care plan that is not up to date. **[Not proved]**

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

Background

Ms Uche was employed by Primelife and commenced employment as a Clinical Lead at Tamworth Court (the Home) on 23 June 2023.

It is alleged that following a formal induction and some training that is said to have taken place between 26 and 30 June 2023, wide ranging concerns about Ms Uche's practice were raised. Her contract was terminated with immediate effect on 30 June 2023 on the grounds that she failed her probationary period.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Edwards. The panel also had regard to Ms Uche's responses and documents that were provided by her to the NMC prior to this hearing.

The panel has drawn no adverse inference from the non-attendance of Ms Uche.

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:

- Witness 1: Not a Registered Nurse and a Non-clinical Registered Manager at the Home.

- Witness 2: HR Advisor for the Home.

- Witness 3: A former Registered Nurse, now working as a Regional Support Manager.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Contextual Information

The panel was provided with information from the Home that Ms Uche commenced her post on Monday 26 June 2023. Witness 2, the HR Advisor at the Home has stated that Ms Uche received formal induction and training between 26 and 30 June 2023. The panel was not provided with any documentary evidence of Ms Uche's record of training or formal induction.

In her oral evidence Witness 3 told the panel that she visited the Home on 26 and 27 June 2023. She told the panel that she was not informed that these were Ms Uche's first two days of work and she was unaware of this until she attended the hearing to give evidence. Witness 3 told the panel that during her visit, she saw no evidence of Ms Uche receiving any training or formal induction.

The panel had regard to Ms Uche's responses and to the Royal College of Nursing's (RCN) written submissions on her behalf dated 16 October 2024, and in particular, the following:

> *'19. The registrant was employed for a matter of five days in total which has led to this NMC referral, during this period she will say that she was provided with little*

to no support from her employers. The registrant maintains she was not given a formal induction.'

In the absence of any direct or contemporaneous evidence, the panel found that it was more likely than not that Ms Uche did not receive any training or a formal induction before her employment was terminated on 30 June 2023.

Charge 1

The panel noted that charge 1 primarily relates to Ms Uche allegedly entering inaccurate information in Resident A's risk assessment and/or plan of care. The panel carefully considered all of the evidence before it, and found that it had not been provided with any contemporaneous documentary evidence with what was alleged to be the *'correct information'* in respect of Resident A. The panel considered that this evidence could have been provided in the form of care plans for Resident A, completed prior to the week of 26-30 June 2023, care plans completed for Resident A completed after the week of 26-30 June 2023, or direct evidence from nurses employed at the Home who knew Resident A well at the time. The panel also noted that the forms contained questions in the first person, and it heard no evidence from a clinical member of staff who could clarify who was expected to complete this part of the form.

Charge 1.1

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.1 That Resident A was weight bearing when they were not.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1.

The panel had sight of Resident A's *'Plan of Care-mobility'* that was created by Ms Uche on 28 June 2023. The panel noted that in the *'Needs'* section, next to the question *'Are you weight bearing?'*, *'YES'* was recorded. The panel noted that this response was circled, and it heard evidence from Witness 1 that this had been circled by a registered nurse to highlight that this entry was incorrect. The panel heard no evidence from the nurse who allegedly circled the entry. It was also not provided with any evidence for it to be able to conclude that Resident A was not weight bearing.

Having regard to all of the evidence before it, the panel determined that the NMC had failed to discharge its evidential burden. Accordingly, the panel found this charge not proved.

Charge 1.2

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.2 That Resident A did not have a history of falls when they did.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it.

The panel had sight of Resident A's *'Plan of Care-mobility'* that was created by Ms Uche on 28 June 2023. The panel noted that in the *'Needs'* section, next to the question *'Do you have a history of falls?'*, *'no'* was recorded. The panel noted that this response was circled, and it heard evidence from Witness 1 that this had been circled by a registered nurse to highlight that this entry was incorrect. The panel heard no evidence from the nurse who allegedly circled the entry. It was also not provided with a falls risk assessment or incident forms to support that Resident A had a history of falls.

Having regard to all of the evidence before it, the panel determined that the NMC had failed to discharge its evidential burden. Accordingly, the panel found this charge not proved.

Charge 1.3

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.3 That Resident A was a medium risk of falls when they were a high risk of falls.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it.

The panel had sight of Resident A's *'Plan of Care-mobility'* that was created by Ms Uche on 28 June 2023. The panel noted that in the '*Risk of Assessment'* section, in the table containing information about Resident A's risk of falls, it was recorded as a medium risk.

The panel heard evidence from Witness 1 that Resident A was at a high risk of falls, however she was unable to provide any specific evidence to support this. The panel was also not provided with a falls risk assessment or incident forms to support that Resident A had a history of falls or was at high risk of further falls.

Having regard to all of the evidence before it, the panel determined that the NMC had failed to discharge its evidential burden. Accordingly, the panel found this charge not proved.

Charge 1.4

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.4 That Resident A required a normal mattress when they required an airflow mattress.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it.

The panel had sight of Resident A's *'Plan of Care-mobility'* that was created by Ms Uche on 28 June 2023. The panel noted that in the *'Needs'* section it was recorded that Resident A *resides on a profiling bed'.* The panel also noted that in the *'Action and Safety Strategies for Staff/Carers'* section, it was recorded that Resident A was *'nursed on an[sic] normal mattress and profiling bed whilst in bed.'* The panel noted that this entry had been circled and *'Airflow mattress'* had been handwritten at the top of the document. The panel heard evidence from Witness 1 who said that a profiling mattress is an airflow mattress. The panel found the evidence in respect of this to be unclear and inconsistent.

Witness 1 told the panel that Ms Uche had incorrectly recorded the type of mattress needed by Resident A and the entry had been circled by a registered nurse to highlight that this entry was incorrect. The panel noted that nurse who allegedly circled the entry was not called to give evidence at this hearing and had not provided a statement. The panel also found no evidence of what Resident A's mattress requirements were. The panel also noted that Witness 1 was inconsistent and lacked clarity in identifying different types of mattresses and/or beds.

Having regard to all of the evidence before it, the panel determined that the NMC had failed to discharge its evidential burden. Accordingly, the panel found this charge not proved.

Charge 1.5

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.5 Referred to Resident C instead of Resident A.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1 and the written submission provided by the Royal College of Nursing (RCN) on behalf of Ms Uche dated 16 October 2024

The panel had sight of Resident A's *'Plan of Care- mobility'* that was created by Ms Uche on 28 June 2023. The panel noted that in the section entitled *'Action and Safety Strategies for Staff/Carers'* Resident C's name had been incorrectly entered.

The panel had sight of written submissions provided by the RCN and noted the following acknowledgement:

> *'11. The registrant acknowledges that a minor omission was made, in the care plan with the incorrect resident's name. It is noted that this was only listed once in the care plan and the top of the care plan identifies the correct resident.'*

Having regard to all of the evidence before it, the panel was satisfied that it was more likely than not that Ms Uche referred to Resident C instead of Resident A once on Resident A's care plan when identifying the room, but correctly referred to Resident A whenever referring to Resident A's clinical needs. The panel therefore found this charge proved.

Charge 1.6

1. On or around 26 June 2023 documented the following inaccurate information in Resident A's risk assessment and/or plan of care:

1.6 That the gap of bed edge was 6 metres when it was 6mm.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1.

Witness 1, in her evidence, told the panel that when discussing the matter with Ms Uche, Witness 1 *"plucked 6mm out of the air"* to show that 6 metres could not be correct. The panel had no evidence before it to demonstrate that 6mm was ever a correct measurement. The evidence suggested that a gap of more than 6cm between a mattress and a bedframe could be an entrapment hazard.

The panel had sight of an untitled document produced as evidence by the NMC which Witness 1 told the panel she did not recognise but she said *"it looked like something Ms Uche created herself"*. The panel noted this document recorded *'risk of head trap and hand trap when gap between the edges of the bed is more than 6cm'*. The panel also noted that in another column on a different page, the following had been recorded *'6 metres gap of bed edge should be monitored…'*.

The panel found that in view of the lack of inherent sense in the charge, on the balance of probabilities, Ms Uche partially recorded accurate information on the risk assessment and/or plan of care and made a simple typographical error, and that the NMC had failed to discharge its evidential burden. Accordingly, the panel found this charge not proved.

Charge 2.1

2. Having documented incorrect information in Resident A's risk assessment and/or plan of care, as set out in charge 1, sent such documentation to a safeguarding officer at the local authority:

2.1 On 26 June 2023.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it.

The panel noted that the only Plan of Care/Risk Assessment provided was created on 28 June 2023. The panel therefore found that it would not have been possible to send this document on 26 June 2023. Accordingly, the panel found this charge not proved.

Charge 2.2

2. Having documented incorrect information in Resident A's risk assessment and/or plan of care, as set out in charge 1, sent such documentation to a safeguarding officer at the local authority:

2.2 On 28 June 2023.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it.

The panel was mindful that the only part of charge 1 that it had found proved was that Ms Uche had mistakenly entered Resident C's name in Resident A's Plan of Care and will consider this charge on that basis.

The panel had sight of an email sent by Ms Uche to a Solihull government email address on 28 June 2023. In this email, Ms Uche stated that she had attached a mobility care plan. The panel noted that the attached Plan of Care contained reference to Resident C. Accordingly, that panel found this charge proved.

Charge 3

3. On or around 27 June 2023, failed to recognise that thickener prescribed for one resident could not be used for another resident.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1 and Witness 3 and Ms Uche's responses during the meeting on 30 June 2023 and to the RCN submissions sent on her behalf.

The panel has regard to the NMC witness statement of Witness 1 in which she stated the following:

> *'Ms Uche wanted to use one bottle of thickener for all the residents and when I asked her about it, she said that it was all the same stuff. I told her that you had to use what was prescribed to the individual only. She just kept saying that it was the same medication, which it was, but it had been used as described. I tried to explain it to her by saying that if the CQC walked through the door, they would not be happy if one resident's thickener had all been used whilst others appeared to not have had any.'*

In her oral evidence, Witness 3 told the panel that she saw dispensing labels on the thickener, and said: *"it had a specific named patient prescription label attached"* and explained it could not be used for general use. She said that thickener can only be used for the particular resident for which it had been prescribed. The panel noted that Witness 3 was a former Registered Nurse.

The panel had sight of the notes of minutes of a meeting that took place on 30 June 2023 in which it is recorded that Ms Uche said the following:

> *'A care support they gave it to me – I said it needs to be stored away and it is only for one person but if it is a life and death emergency you can go and get the stock inside the clinical room and take some...*
>
> *NO I said we can go on the stock and see if there is anyone else, we can get one from, its [sic] not kept in the kitchen it needs to be on the trolleys or clinical room.'*

The panel also had sight of written submissions provided by the Royal College of Nursing (RCN) on behalf of Ms Uche dated 16 October 2024. It noted the following:

The panel noted that Ms Uche, in the meeting dated 30 June 2023 and in the RCN written submissions dated 16 October 2024, appears to attempt to provide context to her stating that she could give one resident's prescribed thickener to another. However, the panel noted that the meeting minutes dated 30 June 2023 had not been signed by Ms Uche. Furthermore, the panel considered that whilst she maintained her denial of this allegation, her accounts were inconsistent.

The panel heard oral evidence from Witness 1 and Witness 3 which found it to be consistent with their NMC witness statement and contemporaneous written statements. The panel therefore found their evidence, given on oath, to be credible and reliable in respect of this charge and placed greater weight on, and preferred the evidence of Witness 1 and Witness 3. The panel determined that it was more likely than not that Ms Uche failed to recognise that thickener prescribed for one resident could not be used for another resident. Accordingly, the panel found this charge proved.

Charge 4.1

4. On or around 27 June 2023;

4.1 Sought to undertake a medication round when you had not completed a medication competency using the Primelife format.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1 and Witness 3.

The panel had sight of Witness 1's NMC witness statement in which she stated the following:

'Each new member of staff has to complete a medication competency and they also have to do online training before they would be expected to be administering residents' medication. At the Home, it was possible for a trained nurse to administer medication under their own PIN, so it was not mandatory for them to complete the training…

On that same day, the nurse on the ground floor had not arrived, so Ms Uche said she would do the medications. I told her she should absolutely not do this as she had not completed her training, and she responded to this stating that she was a nurse. She did not like it when I said that to her, but this is our Home policy, and she was aware as this was part of her induction.'

In her oral evidence, Witness 1 told the panel that it was mandatory for nurses to complete medication training before administering medication to residents. The panel considered that her evidence in respect of this whether a nurse could undertake a medication round without completing the training was unclear. The panel also found, as set out above, that it was more likely than not that Ms Uche had not received a formal induction or training in the five days she worked at the Home.

The panel had sight of Witness 3's NMC witness statement in which she stated the following:

'The nurse for the ground floor had not arrived and so Ms Uche said she would do medications and when she was advised by [Witness 1] that she could not do this as she had not completed her training, she responded stating that she was a nurse.'

In Witness 3's oral evidence, she told the panel that she was unaware that it was Ms Uche's first day and that she saw no evidence of an induction or training taking place.

The panel considered that there is evidence that Ms Uche sought to assist the Home in undertaking a medication round when another nurse had not attended work. The panel also heard evidence from Witness 3 that during her visit, there was no evidence of an

induction or training taking place, and that she was unaware until she attended this hearing that Ms Uche had just started her post. Whilst the panel found this charge factually proved, the panel will consider the seriousness of Ms Uche's actions in these particular circumstances at the next stage.

Charge 4.2

4. On or around 27 June 2023;

4.2 Sought to *'run medications'* that was prohibited by the Home.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1 and Witness 3. The panel also had regard to Ms Uche's responses.

The panel had regard to Witness 1's NMC witness statement in which she stated the following:

> *'In the Home, however, we are not allowed to "run medications". This is where one person dispenses the medications and uses the computer to record the medication being dispensed and a second person then takes the medicines to each resident.*
>
> *Ms Uche came up to me one of the days and told me that she was going to "run medications". I told her that we were not allowed to do that, and she questioned why as she said that it was quicker. I told her that it was the procedure here and that it was better to be slower and safer. I told Ms Uche that my carers were not trained to give medications to any of the residents and that it was expected that she would follow the policy. Ms Uche did not seem to understand the reasons I was giving and just wanted to get the job done quickly. The risk was that the second person who would be taking the medication to the residents*

could be taking it anywhere and there is not that direct confirmation that the medication has been delivered by a nurse or senior carer directly to the resident.'

The panel had regard to the RCN written submissions dated 16 October 2023 in which the following is stated:

'17. The registrant instructs us that she washed the medication pots, dried them together with the spoons as there were not enough medication pots and spoons which would have resulted in a delay in administering the medication. She will say that she was trying to be supportive and helpful at the time.

18. The registrant instructs us that as she was in her induction period and was observing medication rounds, she was not authorised to administer medication during this time. We are instructed that she did not have any intention to pre-pot and sign for medication while another nurse administered it. It is submitted that an assumption has been made which was not the registrant's intentions.'

The panel heard no direct evidence from anyone who witnessed Ms Uche '*running medications'*.

The panel had regard to Ms Uche's responses during the meeting on 30 June 2023. The panel noted that when the allegations arose, Ms Uche was in the first week of her employment at the Home. From Ms Uche's responses, the panel considered that it appeared that she was shadowing and assisting another registered nurse who was completing a medication round.

The panel was of the view that the evidence in respect of this charge was unclear and inconsistent. The panel considered that in the absence of any direct evidence, it was more likely than not that there had been a miscommunication and that Ms Uche had not intended on *'running medications'*. Accordingly, the panel determined that the NMC had failed to discharge its evidential burden and found this charge not proved.

Charge 5

5. On or around 28 June 2023, having suspected that Resident B had an adverse reaction to their medication, failed to:

5.1 Check and/or ensure that Resident B's vital signs were taken.
5.2 Call and/or ensure that 111 / GP was called for advice.
5.3 Consider and/or ensure that a referral to the Tissue Viability Nurse was made.

This charge is found not proved in its entirety.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Witness 1 and it had regard to Ms Uche's responses.

The panel noted that when this charge arose, Ms Uche was within her induction period and had not completed the required training which would have allowed her to have carried out her nursing role without supervision. The panel had regard to the NMC witness statement of Witness 1 in which the following is stated:

> *'On 28 June 2023, Ms Uche approached me to explain that the patient in room 5 had a blister on his neck and that she thought it could be a reaction to the medication given. When I asked her the actions she had taken, she stated that she placed the patient down and for him to be reviewed by the GP on the next visit. Ms Uche was unaware of when the GP's next visit would be. I expressed that even if the next visit was in 12 hours' time, leaving the issue till the next day meant allowing nurses to administer the medication again, which Ms Uche believed gave the patient an adverse reaction…*
>
> *… Another agency nurse present took the appropriate steps and emailed the GP. When I then asked Ms Uche why she had not emailed the GP, she said she could not use the computer and the system.'*

In her oral evidence, Witness 1 told the panel that in situations where a Resident's condition may need escalating, a meeting would take place between her, the nurse in charge and any other relevant member of staff. The panel heard no evidence that Ms Uche was under an obligation to undertake vital signs, escalate concerns to the GP/111 and refer to a Tissue Viability Nurse.

The panel noted from the minutes of the meeting on 30 June 2023 that vital signs were taken and that the concerns were escalated to the GP. The panel found no evidence that vital signs were taken by someone else because Ms Uche did not. The panel also found that there was no evidence to suggest that someone else escalated concerns to the GP because Ms Uche did not. The panel also noted that there was no evidence that Ms Uche should have escalated her concerns to the Tissue Viability Nurse.

The panel had regard to RCN written submissions on behalf of Ms Uche dated 16 October 2023 in which the following is stated:

> *'14. We are instructed by the registrant that she took immediate action when she observed a blister on the resident. She will say that she escalated this to the nurse in charge, who had informed and reassured her that the GP had been made aware of it and that the GP was going to review the patient the following morning. It is profusely denied that she would just leave the resident and considers that she escalated the resident appropriately at the time.*
>
> *15. The registrant instructs us that she observed the blister, the resident was not in any distress, and she made the resident comfortable.*
>
> *16. We are instructed that she spoke to the GP the following morning about this resident and queried the blister to which she was reassured that the blister was being managed appropriately.'*

On the date in question, the panel noted that Ms Uche was in her first week of work, and there was evidence that she had not completed her induction or training. Having regard to all of the evidence before it, the panel determined that the NMC had failed to discharge its evidential burden and found this charge not proved in its entirety.

Charge 6

6. Between 23 June 2023 and 30 June 2023, on one or more occasions, created and/or completed residents care plans:

6.1 Before the resident had arrived at the Home.
6.2 Without attending and/or assessing the resident.
6.3 Using previous data contained in the care plan that is not up to date.

This charge is found not proved in its entirety.

In reaching this decision the panel had regard to all of the evidence before it.

The panel heard evidence from Witness 1 who said that there were occasions in which it would be appropriate for care plans to be created before a resident arrives at the Home. When asked for specific information in respect of this charge, Witness 1 was unable to assist the panel.

The panel noted that it had not been provided with specific information or evidence in relation to this charge which would have confirmed the date of arrival, care plans dated before residents arrived at the Home, or outdated care plans. In the absence of such evidence, the panel determined that the NMC had failed to discharge its evidential burden and found this charge not proved in its entirety.

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 Ms

Uche'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. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Uche's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Edwards invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Mr Edwards identified the specific, relevant standards where in his submission, Ms Uche's actions and omissions may have amounted to misconduct.

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 also considered whether each charge that was found proved individually amounted to misconduct.

In respect of charge 1.5, as previously set out, the panel found that Ms Uche mistakenly entered Resident C's name incorrectly into Resident A's Plan of Care. The panel noted that this single clerical error happened within the first days of her starting her new role, and the Plan of Care correctly referred to Resident A whenever referring to their clinical needs. The panel was of the view that this isolated error was not serious and would not be considered as deplorable to a fellow practitioner. The panel therefore found that the conduct in charge 1.5 did not amount to misconduct.

In considering charge 2.2, the panel had regard to its finding that charge 1.5 did not amount to misconduct. The panel was of the view that whilst Ms Uche emailed incorrect information to the Local Authority, given the nature of the incorrect information as set out above, this did not amount to misconduct. The panel considered that as there was only one small error, and the subject line of the email referred to Resident A, the recipient would have been in no doubt that the Plan of Care related to Resident A.

In respect of charge 4.1 the panel had regard to its findings at the facts stage, namely that Ms Uche sought to assist the Home in undertaking a medication round when another nurse had not attended work. As a Registered Nurse, the panel considered that it was not unreasonable for Ms Uche to offer to undertake a medication round when a member of staff had not attended work as expected. The panel found that there was no evidence that Mrs Uche had received a formal induction plan, or that she was aware of the policy that prohibits the administration of medication until the relevant training had been completed. The panel considered that a fellow practitioner would not consider Ms Uche's offer to undertake a medication round deplorable in the circumstances. The panel therefore found that the conduct at charge 4.1 was not so serious as to amount to misconduct.

In respect of charge 3, the panel found that Ms Uche breached the following parts of the Code:

> *'**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.'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in failing to recognise that thickener prescribed for one resident could not be used for another resident was serious. The panel considered that as a Registered Nurse, regardless of what induction training she had, Ms Uche should have known that a substance prescribed for one resident could not be used for another. The panel was of the view that if the wrong thickener was given to the wrong resident, this presented a risk of harm. The panel was also of the view that a fellow practitioner would consider Ms Uche's conduct at charge 3 to be deplorable. Accordingly, the panel found that Ms Uche's actions fell significantly short of the standards expected of a registered nurse in respect of charge 3, and that her actions amounted to misconduct.

Submissions on impairment

Mr Edwards moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Edwards referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and submitted that the panel may consider that in respect of the *Shipman* test, limbs a, b and c are engaged in this case.

He also referred the panel to the case of *Cohen* and submitted that it is clear that the conduct in charge 3 which led to the finding of misconduct is easily remediable. Mr Edwards submitted that there is no evidence that Ms Uche has remediated the concerns. He drew the panel's attention to Witness 1's witness statement in which she

stated that when she challenged Mrs Uche in relation to the thickener, Ms Uche appeared to fail to understand that the thickener could only be used for the resident that it was prescribed for. Mr Edwards also submitted that Ms Uche appeared to demonstrate a lack of insight into her failing and from the evidence of Witness 1, Ms Uche did not respond well to guidance or criticism.

Mr Edwards submitted that there are limited responses from Ms Uche and no information about what she is currently doing, or whether she has completed any further training and strengthened her practice. He conceded that there is no suggestion that any resident was harmed and there is nothing to suggest that any other issues of a similar nature have been raised since these charges arose.

Mr Edwards submitted that determining whether Ms Uche is currently impaired on public protection and public interest grounds is ultimately a matter for the panel. He reminded the panel that Ms Uche's non-attendance should not be held against her.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Meadow v General Medical Council* [2006] EWCA Civ 1390, *Cohen* and *Holton v GMC* [2006] EWHC 2960 (Admin) and *Grant*.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

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

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

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

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

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

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

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

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

d) *…'*

The panel found limbs a, b and c engaged. The panel considered that in failing to recognise that thickener prescribed for one resident could not be used for another, Ms Uche placed patients at an unwarranted risk of harm. Having found that Ms Uche placed residents at unwarranted risk of harm, the panel considered that she brought the profession into disrepute. The panel considered that as patient safety is a fundamental tenet of the profession, Ms Uche's actions as set out in charge 3, amounted to a breach of this limb.

The panel went on to consider the case of *Cohen* and was of the view that the misconduct identified was easily remediable as it was clinical in nature and could therefore be addressed through retraining.

The panel noted that it had not been provided with any evidence of reflection or insight. It noted that in the RCN written submissions on behalf of Ms Uche on 16 October 2024, the following was stated:

'19. In respect of concern 4 (b), the registrant instructs us that she found a resident's thickener in the kitchen area. She recalls asking the carer who put it in the kitchen and warned them that they cannot leave the thickener in the kitchen and further instructed her that they cannot use the thickener on other patients.'

The panel also had regard to Ms Uche's responses in the meeting on 30 June 2023 in which she recognised that giving thickener to residents for whom it was not prescribed

for was not good practice. However, the panel also had regard to the inconsistent responses she gave in this meeting. Whilst Ms Uche may accept that thickener could only be used for the resident for whom it was prescribed, the panel had no evidence to suggest that this potential understanding has been embedded into her practice through reflection and/or training. The panel was also mindful of the most recent email communications from Ms Uche to the NMC, in which the panel considered that Ms Uche's acceptance of the concerns and insight was limited. In the absence of any reflection, remediation or strengthened practice, and without any evidence given to this panel that she has worked in a healthcare related role, the panel determined that the risk of repetition of the misconduct is high. Having found that the risk of repetition of is high, the panel determined that there is a consequent risk of harm to patients. The panel therefore considered that a finding of impairment was necessary on the ground of public protection.

The panel determined that a finding of impairment on public interest grounds is required because having found that a fellow practitioner would consider Ms Uche's actions to be deplorable, and that there is a continuing risk to the public given Ms Uche's lack of understanding about the appropriate use of prescribed substances, the public would expect a finding of impairment. The panel also concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore found Ms Uche's fitness to practise impaired on the grounds of public interest.

The panel had regard to the NMC Guidance on *'Impairment'* and considered that in light of all of the above, Ms Uche is not currently capable of practising *'kindly, safely and professionally'*.

Taking into account all of the evidence before it, and the considerations as set out above, the panel concluded that Ms Uche's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 6 months. The effect of this order is that Ms Uche's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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 Edwards submitted that in light of the panel's findings that charge 3 amounted to misconduct and that Ms Uche's fitness to practise is currently impaired. He set out some factors that, in the NMC's submission are aggravating and mitigating in this case.

Mr Edwards submitted that whilst determining what is the most appropriate and proportionate sanction is a matter for the panel, the NMC sanction bid is for either no further action or a caution order.

Decision and reasons on sanction

Having found Ms Uche'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:

- Ms Uche has demonstrated limited insight into her failings.
- There is a lack of evidence of Ms Uche's ongoing training and attempts to strengthen her practice.

- Ms Uche's misconduct which placed patients at risk of unwarranted harm.
- Ms Uche's failings related to basic nursing care.

The panel also took into account the following mitigating features:

- No actual harm was caused by Ms Uche's failings.
- This was an isolated incident.
- There is no evidence any misconduct or misconduct of a similar nature being repeated.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of 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 public protection issues identified, an order that does not restrict Ms Uche'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 Ms Uche's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the public protection 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 Ms Uche'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, and found that the following factors were applicable in the circumstances of this case:

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

- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *…;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

Having found that the above factors are applicable to this case, the panel determined that it would be possible to formulate relevant, proportionate workable and measurable conditions which would address the failings highlighted in this case. As previously set out, the misconduct found was clinical in nature and capable of being addressed through retraining. The panel therefore determined that that the appropriate and proportionate sanction is that of a conditions of practice order. The panel was of the view that a conditions of practice order would protect patients and allow Ms Uche the opportunity to address the shortfall in her practice.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a Registered Nurse.

The panel was of the view that to impose a suspension order disproportionate and would not be a reasonable response in the circumstances of this case.

The panel determined that the following conditions are appropriate and proportionate in this case:

> *'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of*

educational study connected to nursing, midwifery or nursing associates.'

1. You must limit your nursing practice to a single substantive employer which must not be an Agency.

2. You must ensure that you are directly supervised by another Registered Nurse when undertaking medication administration until you have undertaken a medication administration assessment and are signed off as competent by another Registered Nurse.

3. You must provide a copy of this assessment, signed by the Registered Nurse who completed the medication administration assessment, to your Case Officer at the NMC within 14 days of the completed assessment.

4. You must meet with your line manager or supervisor at least once a month to discuss your performance in relation to medication administration.

5. You must obtain a report from your line manager or supervisor before this order is reviewed and provide it to your NMC Case Officer. This report must contain details of your performance in relation to medication administration.

6. You must keep us informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

7. You must keep us informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.

b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).
   c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is 6 months.

Before the order expires, a panel will hold a review hearing to see how well Ms Uche has complied with the order.

Any future panel reviewing this case would be assisted by:

- Ms Uche completing further training in medication administration.
- Evidence of professional development, including documentary evidence of completion of the above mentioned training.
- A reflective statement in which Mrs Uche addresses the misconduct found.

Interim order

As the conditions of practice 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, or is otherwise in the public interest or in Ms Uche's own interests until the conditions of practice sanction takes effect.

Submissions on interim order

Mr Edwards made an application for interim conditions of practice order for a period of 18 months on public protection and public interest grounds. He submitted that given the imposition of the substantive conditions of practice order, it is necessary and proportionate to impose an interim conditions of practice order to address the public protection and public interest issues identified by the panel. Mr Edwards submitted that given the potential delay in consideration of appeals, 18 months is the most appropriate length of time to allow for any appeal to be determined.

The panel accepted the advice of the legal assessor which included reference to the case of *Hindle v NMC [2025] EWHC 373.*

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 public protection issues identified, namely that there is a real risk of significant harm if Ms Uche was able

to practise without restriction. The panel also had regard to the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to impose any other interim order would be inconsistent with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Ms Uche is sent the decision of this hearing in writing.

That concludes this determination.

This will be confirmed to Ms Uche in writing.