Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 14 July 2025 – Friday 18 July 2025

Virtual Hearing

Name of Registrant:	Mohamad Kanu
NMC PIN:	07A0015C
Part(s) of the register:	Nurses part of the register Sub part 1 RN1, Registered Nurse - Adult nurse (09 January 2007) RN3, Registered Nurse - Mental health nurse, level 1 (05 January 2007)
Relevant Location:	Braddan, Isle of Man
Type of case:	Misconduct
Panel members:	Liz Dux (Chair, Lay member) Jason Flannigan-Salmon (Registrant member) Rachel Merelie (Lay member)
Legal Assessor:	Graeme Dalgleish
Hearings Coordinator:	Monowara Begum
Nursing and Midwifery Council:	Represented by Vida Simpeh, Case Presenter (14 July 2025 - 17 July 2025) Simran Ghotra, Case Presenter (18 July 2025)
Mr Kanu:	Not present and not represented at the hearing
Facts proved:	Charges 1, 2a, 2b, 3, 8, 9a, 9b and 10
Facts not proved:	Charges 4, 5, 6 and 7
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Kanu was not in attendance and that the Notice of Hearing letter had been sent to Mr Kanu's registered email address by secure email on 13 June 2025.

Ms Simpeh, 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 that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Kanu's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Kanu

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

Ms Simpeh referred the panel to the email from Mr Kanu dated 14 July 2025, stating the following:

'Unfortunately am not capable of attending. [PRIVATE].
Please represent me to your level best.'

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mr Kanu;
- Mr Kanu has emailed the Hearings Co-Ordinator on the morning of the hearing, 14 July 2025, to state that he will not be attending the hearing [PRIVATE];
- Mr Kanu was sent an email by the Hearings Co-Ordinator in response to his email dated 14 July 2025, phone calls were made, and a voice message was left on voicemail to seek clarification of his attendance, and no response was received from either communication;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- 5 witnesses have been scheduled and are due to attend this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2023;

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

There is some disadvantage to Mr Kanu in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he has made no detailed response to the allegations. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies, taking into consideration Mr Kanu's two reflective accounts as well as the NMC context form. Furthermore, the limited disadvantage is the consequence of Mr Kanu's decisions to absent himself from the hearing and to not provide evidence or make submissions on his own behalf.

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

Decision and reasons on application to admit hearsay evidence of Patient A

At the outset of the hearing, Ms Simpeh made an application for the account of Patient A as referred to in Charge 9, as set out in the witness statement and exhibits of Witness 1, to be admitted into evidence as hearsay. She referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and submitted that this case laid out the following factors to be considered in admitting hearsay evidence and she addressed five of the seven factors respectively:

i. Whether the statements were the sole and decisive evidence in support of the charges:

Ms Simpeh submitted that the evidence goes to Charge 9, and it is the sole and decisive evidence for this charge. However, she also submitted that this evidence is supported by the documentary evidence of Witness 1 and Witness 5. She further submitted that Witness 1 and Witness 5 would be attending the hearing and there would be an opportunity for their evidence to be challenged and tested by the panel.

ii. The nature and extent of the challenge to the contents of the statements:

Ms Simpeh submitted that Mr Kanu has not challenged the evidence despite having the opportunity to do so.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Ms Simpeh submitted that there was no suggestion of fabrication and no evidence of any motivation to fabricate the allegations made against Mr Kanu.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Ms Simpeh submitted that the allegations are serious, and it is accepted that there would be a detrimental impact on Mr Kanu's career.

v. Whether there was a good reason for the non-attendance of the witness:

Ms Simpeh submitted that the reason for the non-attendance of the witness was due to Patient A [PRIVATE]. She referred the panel to the email correspondence between the NMC and Witness 1 in the hearsay bundle which confirmed this.

In conclusion, Ms Simpeh submitted that the hearsay evidence is admissible as the evidence is relevant and fair.

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

In reaching its decision, the panel considered the case of *Thorneycroft*. The panel considered the evidence of Patient A and determined that the gravity of Charge 9 is a relevant factor. The panel determined that there are strong reasons to not call Patient A in to give evidence [PRIVATE].

The panel determined that the evidence of Patient A is not the sole and decisive evidence as both Witness 1 and Witness 5 separately report the alleged incidents. The panel noted that Witness 1 and Witness 5 will be giving evidence during the hearing and therefore the panel will be able to ask both the witnesses about the evidence in more detail and so is able to test the evidence.

The panel noted that this evidence has not been challenged by Mr Kanu and that he appears to accept what allegedly happened in relation to the conversation that took place.

The panel concluded that it would be fair and relevant to accept the hearsay evidence of Patient A in relation to Charge 9. After hearing all the evidence, the panel will decide how much weight should be attached to this evidence.

Decision and reasons on application to admit hearsay evidence of Witness 3

Ms Simpeh made a further application for the witness statement and exhibits of Witness 3 to be admitted into evidence as hearsay. She referred the panel again to the case of *Thorneycroft* and addressed six of the seven factors in turn:

i. Whether the statements were the sole and decisive evidence in support of the charges:

Ms Simpeh submitted that the evidence goes to Charges 1, 2, 5 and 7, and it is not the sole and decisive evidence for these charges. She submitted that Charge 1 can be tested through the evidence of Witness 1 and Witness 2, as well as Mr Kanu's reflective account. She submitted that Charge 2 can be tested through the evidence of Witness 1 and Witness 2, and Charge 5 can be tested through the evidence of Witness 1 and Witness 4. She further submitted that Charge 7 can be tested through the evidence of Mr Kanu's reflective account in relation to completing assessments and the matters raised by him about training.

ii. The nature and extent of the challenge to the contents of the statements:

Ms Simpeh submitted that Mr Kanu has not challenged the allegations, however, the panel can consider the matters set out in his reflective account.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Ms Simpeh submitted that there is no evidence to suggest that the evidence of Witness 3 is fabricated and there is no evidence of any motivation to fabricate the evidence.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Ms Simpeh submitted that the allegations are serious, and it is accepted that there would be a detrimental impact on Mr Kanu's career. She submitted that the evidence is relevant to a number of charges. She further submitted that the evidence is fair, and its reliability can be assessed and tested through the evidence of other witnesses as well as Mr Kanu's reflective account.

v. Whether there was a good reason for the non-attendance of the witness:

Ms Simpeh referred the panel to the email correspondence between Witness 1 and the NMC, dated 11 July 2025, which states that Witness 3 is not in a position to give evidence.

vi. Whether the regulator had taken reasonable steps to secure the witness's attendance:

Ms Simpeh submitted that reasonable steps had been taken to secure the witness's attendance.

In conclusion, Ms Simpeh submitted that the hearsay evidence may be admissible as the evidence and exhibits are relevant and fair.

The panel accepted the legal assessor's advice.

The panel considered the evidence of Witness 3 and determined that it is not the sole and decisive evidence, and these charges can be appropriately tested against the evidence of Witness 1, Witness 2, Witness 5 and Mr Kanu's reflective accounts. The panel noted that Mr Kanu had the opportunity to consider and challenge the evidence.

The panel noted that the NMC has made good efforts to secure the attendance of Witness 3. It had sight of the email dated 11 July 2025 and determined that the absence cannot be helped and there is a good reason for the non-attendance.

The panel concluded that it would be fair and relevant to accept into evidence the witness statement and exhibits of Witness 3, in relation to Charges 1, 2, 5 and 7. After hearing all the evidence, the panel will decide how much weight should be attached to this evidence.

Details of charge

That you, a registered nurse:

While employed by Harbour Suite between 8 May 2023 and 20 June 2023:

1) On or about 26 May 2023 gave Chlordiazepoxide to a patient instead of Paliperidone.

2) Following the incident in charge 1 above,
   a) Did not inform the patient that you had administered incorrect medication for a period of approximately 2-3 hours
   b) Did not complete an incident report.

3) Your actions at charges 2 a) and/or 2 b) demonstrated a lack of candour in that you failed promptly to inform the patient of the medication error and/or ensure that it was recorded as a medication incident.

4) On or about 28 May 2023 advised the patient referred to in charge 1 above that a direction to take medication 4 hourly meant it could be taken by the Patient 4 times a day

5) On or about 5 June 2023, failed to inform your shift-coordinator that you had not completed an admission form and/or seek assistance to complete it prior to handover

6) On or about 15 June 2023, gave a discontinued antibiotic to a patient.

7) On an unknown date, failed to inform your shift coordinator that your were unable to obtain a mental health score or seek assistance to complete it prior to handover.

8) On an unknown date, did not carry out a risk assessment and/or establish whether one had already been carried out, prior to allowing a patient to go on leave.

9) On an unknown date prior to 4 July 2023:
    a) Asked Patient A for their contact number
    b) Offered to meet with Patient A after their discharge.

10) Your action at charge 9 above was in breach of professional boundaries.

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

Background

The NMC received a referral on 26 June 2023 by the Acute Inpatient Service Manager on Harbour Suite.

Mr Kanu was employed as a Band 6 staff nurse on Harbour Suite on a temporary basis from 8 May 2023. He was given an induction and was shown around the unit, and he spent his first week in the supernumerary capacity as part of his induction. Shortly after commencing employment, a number of concerns were raised by a number of staff relating to Mr Kanu's practice.

The concerns were investigated, and Mr Kanu was given the opportunity to provide reflections and undertake supervision.

On 20 June 2023, Mr Kanu's employment at Harbour Suite ended.

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 Ms Simpeh on behalf of the NMC.

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

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: Ward Manager on Harbour Suite
- Witness 2: Doctor, Associate Specialist Psychiatrist, working as part of the acute inpatient team on Harbour Suite, and providing psychiatric cover to the crisis team
- Witness 4: Band 6 Registered Mental Health Nurse
- Witness 5: Band 6 Registered Mental Health Nurse, at the time of the incidents

The panel also admitted the hearsay evidence from Witness 3, a Band 6 Registered Mental Health Nurse, and Patient A.

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

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

Charges 1, 2a, 2b and 3

1. On or about 26 May 2023 gave Chlordiazepoxide to a patient instead of Paliperidone.

2. Following the incident in charge 1 above,
   a) Did not inform the patient that you had administered incorrect medication for a period of approximately 2-3 hours
   b) Did not complete an incident report.

3. Your actions at charges 2 a) and/or 2 b) demonstrated a lack of candour in that you failed promptly to inform the patient of the medication error and/or ensure that it was recorded as a medication incident.

These charges are found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1, Witness 2 and Witness 4, the hearsay witness statement of Witness 3, the NMC context form completed by Mr Kanu and Mr Kanu's reflective accounts. The panel found all the witnesses to be open, professional, credible and their evidence, both oral and written, was largely consistent.

In relation to Charge 1, the panel determined that the oral and written statements of the witnesses were consistent and were confirmed by the contemporaneous Datix report.

The panel took into account the witness statement of Witness 1, stating:

'On 26 May 2023, Mohamad gave a service user the wrong medication. Mohamad was aware of his mistake, and reported it to the Doctor

[Witness 2], but was reportedly reluctant to tell the patient, and did not raise a Datix when asked to do so'.

The panel also considered the oral and written statement of Witness 2, as follows:

'I was initially concerned on 25 May 2023, when Mohamad came to my office and reported to me that he had accidently given 5mg Chlordiazepoxide to a patient instead of his usual Paliperidone. Thankfully, although Mohamad had given the patient the wrong medication, it was only a very small dose and the patient had previously taken benzodiazepines, therefore this was a low risk mistake and the patient came to no harm as a result of it'.

The panel further considered the hearsay witness statement of Witness 3 and the contemporaneous Datix report, where they stated as follows:

'On 26 May 2023, Mohamad administered Chlordiazepoxide to a patient who was prescribed Paliperidone. I advised Mohamad to raise a Datix to report the incident. Despite being asked, Mohammed did not do this so I completed this'.

The panel noted that Mr Kanu, in his reflective account, appears to admit that the incident had happened, stating:

'I acknowledge the error'.

The panel further noted Mr Kanu's response in the NMC context form, stating:

'When the medicine error happened, I notify the patient and we both agreed that it was a wrong medication'.

In relation to Charge 2a, the panel considered the oral and witness statement of Witness 2, stating:

> *'The same patient later reported to me that he had told Mohamad that he was aware that his medication was wrong, and that over a period of 2-3 hours the patient had asked Mohamad about the error, but that he was not forthcoming with information. The patient reported that he did eventually tell him that he had given him the wrong medication, but that this came after the patient asking Mohamed multiple times'.*

The panel noted that in the Datix report, the following 'action taken' was recorded:

> *'Apparent that Mohammad did make a medication error, this was reported to the doctor, however he was reluctant to tell the patient and did not complete a Datix incident report, despite being instructed to do so'.*

The panel found that there is evidence to suggest that there had been a delay in informing the patient about the incorrect medication, however there was insufficient information to say how long the delay was for. The panel therefore found proved that there was a delay, but were unable to clearly and reliably identify a specific time period.

In relation to Charge 2b, the panel took into account the file note dated 19 June 2023, recorded by Witness 1, stating the following:

> *'26.05.23 – Medication error – patient given Chlordiazepoxide instead of Paliperidone. This was reported to the doctor, however he was reluctant to tell the patient and did not complete a Datix incident report, despite being instructed to do so. Datix was later completed by a colleague …'*

This is corroborated by the witness statement of Witness 1, who said that:

‘On 26 May 2023, Mohamad gave a service user the wrong medication. Mohamad was aware of his mistake, and reported it to the Doctor [Witness 2], but was reportedly reluctant to tell the patient, and did not raise a Datix when asked to do so.’

The panel considered the witness statement of Witness 2, who stated:

‘I asked Mohamad to go and inform the patient of the error, and to record a Datix … I was also advised by a colleague that Mohamad did not complete a datix for the medication error incident, and that another Nurse had completed it after learning of the mistake.’

The panel also considered the hearsay witness statement of Witness 3, which was consistent with the evidence of the other witnesses.

The panel noted that Mr Kanu, in the NMC context form admits to not completing an incident report, stating as follows:

‘I informed the doctor about the patient. After that I tried to document the incident on DATIX, but the system was not allowing me to do it, as it kept going off due to the time setting’.

The panel found that even allowing for Mr Kanu’s reasoning that he had been unable to access the Datix system, there would have been alternative methods for him to provide prompt reporting of the drug error, as recognised by Mr Kanu himself, when he states:

‘I should have documented the incident on a word document, when the system was not allowing me to do it’.

In relation to Charge 3, the panel found that Mr Kanu’s actions in Charge 2a and 2b did demonstrate a lack of candour, as clarified in the joint NMC and GMC guidance,

‘Openness and honesty when things go wrong: The professional duty of candour’ (updated in December 2024):

> *’11. You should speak to the patient as soon as possible after you realise something has gone wrong with their care. When you speak to them, there should be someone available to support them (for example a friend, relative or professional colleague). You do not have to wait until the outcome of an investigation to speak to the patient, but you should be clear about what has and has not yet been established.*
>
> *…*
>
> *23. When something goes wrong with patient care, it is crucial that it is reported at an early stage so that lessons can be learnt quickly and patients can be protected from harm in the future.’*

The panel found that there was no evidence of deliberate intention to mislead or conceal the medication error. Mr Kanu had reportedly it promptly to Witness 2 who confirmed that in his oral evidence. The panel also noted Mr Kanu’s disclosure of the medication error to Witness 2, as stated in his reflective account:

> *‘When the medication error happened, I notify the patient and we both agreed that it was a wrong medication. I was forthcoming with the patient when he informed me about the wrong medication I had administered. I inform the ward doctor about the medication error immediately as it is crucial to notify relevant healthcare professionals, who provided me with guidance on how to handle the situation appropriately’.*

Accordingly, the panel found the evidence to be credible, consistent and cogent and it found charges 1, 2a, 2b and 3 proved.

Charge 4

4. On or about 28 May 2023 advised the patient referred to in charge 1 above that a direction to take medication 4 hourly meant it could be taken by the Patient 4 times a day

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement and file note dated 19 June 2023 of Witness 1. This charge was not covered in the oral evidence and was in any case based on a reported conversation. The panel found this evidence was not sufficiently cogent or clear.

The panel determined that there was insufficient evidence to prove this charge on the balance of probabilities.

Accordingly, the panel found charge 4 not proved.

Charge 5

5. On or about 5 June 2023, failed to inform your shift-coordinator that you had not completed an admission form and/or seek assistance to complete it prior to handover

This charge is found NOT proved.

In reaching this decision, the panel determined that there was clear and credible evidence from Witness 4 that Mr Kanu had failed to complete the progress note. However, the evidence indicates that he did not fully complete the admission form, as stated in her witness statement:

'At handover, (8pm) towards the end of the shift, I asked Mohamed if he had completed the admission that I had asked him to complete. I checked what he had completed, and most of it hadn't been completed, including a progress note for the admission.'

The panel gave some weight to the hearsay witness statement of Witness 3:

'There was an occasion when we had a patient admission and Mohamad was in charge of admitting the patient, carrying out the initial checks, assessments and clinical notes. There is a specific process to carry out when someone is admitted. Mohamad had been shown how to do this, however, even after being given plenty of time to complete the tasks, he did not manage to do so. He did not complete a clinical admission for this patient.'

Whilst the panel found that the evidence indicated that Mr Kanu had not completed an important part of the admission process, namely the progress note, this charge is found not proved as it refers to an admission form which Witness 4 stated in her oral evidence that staff have up to 72 hours after a patient's admission to fully complete.

The panel determined that in relation to the word '*failed'* in the charge, there was no evidence that Mr Kanu was under a duty to complete the entire admission form at that time.

The panel also noted that the charge refers to a failure to inform about not completing the admission form. The evidence of Witness 4 was that Mr Kanu did not inform her that he had not fully completed the progress note, the charge requires evidence of the failure to inform that the entirety of the admission form was not complete.

The panel were not satisfied that Mr Kanu had failed to seek assistance with regard to completing the admission form prior to the handover as there is evidence to suggest that

he had asked for assistance at the start of the process, as stated by Witness 4, albeit that she considered his request for assistance was too onerous.

Accordingly, the panel found charge 5 not proved.

Charge 6

6. On or about 15 June 2023, gave a discontinued antibiotic to a patient.

This charge is found NOT proved.

In reaching this decision, the panel were mindful of the terms in the Datix report, which was reported on 15 June 2023.

In light of what was formally recorded in the Datix report, the panel did not consider that there was clear or sufficient evidence that Mr Kanu had administered a discontinued antibiotic, and determined that it was an error attributed to a *'poorly written / illegible prescription'* and not recorded as the fault of Mr Kanu.

Accordingly, the panel found charge 6 not proved.

Charge 7

7. On an unknown date, failed to inform your shift coordinator that your were unable to obtain a mental health score or seek assistance to complete it prior to handover.

This charge is found NOT proved.

In reaching this decision, the panel took into account the hearsay witness statement of Witness 3 and the file note evidence of Witness 1.

In these circumstances the panel were unable to test the evidence of Witness 3. The panel found that this was the sole and decisive evidence and was not satisfied that there was sufficient, cogent or reliable evidence to prove this charge on the balance of probabilities.

The panel noted that the wording used in the charge was, *'failed to inform'*, however, there is a lack of evidence to suggest there was any duty on Mr Kanu to inform or indeed any failure to do so.

Accordingly, the panel found charge 7 not proved.

Charge 8

8. On an unknown date, did not carry out a risk assessment and/or establish whether one had already been carried out, prior to allowing a patient to go on leave.

This charge is found proved.

The panel having heard, in particular, the compelling and credible oral evidence of Witness 2 which was consistent with their witness statement, in which he stated:

> *'One of the more concerning incidents was when Mohamed insisted he had carried out a risk assessment prior to a patient being able to leave the unit, however there was no documentation to support this…It is obviously vitally important that we accurately assess and document a patients risk and mental state upon leaving the ward due to the nature of patients that we treat and the risks they can pose to themselves and others when suffering from mental illness'.*

The panel noted Witness 2's contemporaneous email evidence dated 22 June 2023, which stated:

> *'I was present for were MK insisting that he risk assessed a patient before they went out on leave but there being no documentation. He recounted where and when it happened with no doubt. He was not aware he needed to document this'.*

The panel was satisfied that it was vital for a properly documented risk assessment to have been carried out with any patient prior to leaving the unit, particularly as it was a secure unit for acute psychiatric patients. In this case, Mr Kanu failed to do so.

The panel also noted that Mr Kanu himself, in his reflective account, acknowledged the importance of this, and stated:

> *'In terms of the concern of record keeping, that I did not document a risk assessment you carried out for a patient to go on leave. Whist coming out the clinical room, I was asked to let the informal patient out on his leave, which I did, with the notion that his paperwork was done. However, once the patient came back from his leave late, it was highlighted that the document was not done completed, which I manage to complete it after his arrival. The risk assessment should have been taken and documented prior to the leave as it is the normal procedure.'*

Accordingly, the panel found charge 8 proved.

Charges 9a-b) and 10

9. On an unknown date prior to 4 July 2023:
    a) Asked Patient A for their contact number
    b) Offered to meet with Patient A after their discharge.

10. Your action at charge 9 above was in breach of professional boundaries.

These charges are found proved.

The panel noted that although Patient A's evidence was hearsay, it was not the sole and decisive evidence, and this evidence was corroborated by Witness 1 and Witness 5. Their evidence was consistent, and each had separately spoken to Patient A about this incident.

The panel had sight of the contemporaneous email evidence of Witness 5 which is consistent with her witness statement, in which she states:

> *'Patient A raised some concerns in relation to the Registrant's conduct and breaching professional boundaries with Patient A, by asking for their number and to meet up with them'.*

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

> *'On 04 July 2023, one of the Nursing staff raised concerns to me that one of the young service users reported that Mohamad had asked for [Patient A] phone number. I spoke with the service user in question and [Patient A] confirmed that Mohamad had asked [Patient A] if [Patient A] wanted to exchange telephone numbers, and suggested they meet up after the service user was discharged.'*

The panel noted Witness 1's email report, dated 4 July 2023, which stated:

> *'I subsequently discussed this allegation with Patient A who confirmed that MK had "asked to exchange numbers" and "meet up when I get out".'*

The panel further noted Mr Kanu's reflective account, where he does not deny the incident and states:

> *'Concerning patient, A' it might have been better not to mentioned telephone numbers in any context at all during our general conversations.'*

Having regard to the extreme vulnerability of the patients, the panel determined that any request for personal details and personal contact outside the clinical setting amounted to a breach of professional boundaries, however well-intentioned it may have been.

Having considered the written and oral evidence of Witness 1 and Witness 5, the hearsay evidence of Patient A, and taking into account Mr Kanu's reflective account, the panel was satisfied that these charges have been found proved.

Accordingly, the panel found charges 9a, 9b and 10 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Kanu'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, Mr Kanu'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 Simpeh invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Simpeh identified the specific, relevant standards where Mr Kanu's actions amounted to misconduct. She submitted that Mr Kanu's actions did fall significantly short of the standards expected of a registered nurse and amounted to breaches of the Code, in particular, 1.2, 10.1, 10.2, 14.1, 14.2, 14.3, 17.1, 20.6. She submitted that Mr Kanu placed patients and members of the public at unwarranted risk of harm.

Ms Simpeh referred the panel to the cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Shaw v General Osteopathic Council* [2015] EWHC 2721 (Admin).

Submissions on impairment

Ms Simpeh 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. She submitted that Mr Kanu's practice is currently impaired. She referred the panel to the cases of *Council for Healthcare Regulatory*

Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Fopma v GMC* [2018] EWHC 714 (Admin).

Ms Simpeh submitted that Mr Kanu was an experienced nurse who had been on the register for around 15 years. She submitted that Mr Kanu should have had a good understanding of what was expected of him. She submitted that Mr Kanu has shown limited insight into his conduct, and although he does recognise how his conduct potentially placed patients at risk of harm, there is no evidence before the panel to demonstrate any steps taken to strengthen his practice. She further submitted that Mr Kanu does not provide any details of practical steps or further training or learning he would undertake to address those issues and to strengthen his practice.

Ms Simpeh submitted that Mr Kanu presented a risk to members of the public and that a finding of impairment was necessary to uphold proper professional standards and maintain public confidence in the profession and so that patients were not placed at further risk of harm.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mr Kanu's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Kanu's actions amounted to a breach of the Code. Specifically, the panel found that his conduct breached the following parts of the Code:

‘8 Work co-operatively

To achieve this, you must:

…

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

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

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

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

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

…

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel accepted that in relation to Charge 1, medication errors can happen, and that in relation to Charge 2b, documenting the error is not always completed by the nurse themselves. However, in this case, there has been a finding of a lack of candour and therefore Charges 1, 2 and 3 in their entirety, are serious enough to amount to misconduct.

In relation to Charge 8, the panel found that taking into account the risks posed both to the public and to vulnerable patients by the omission, that there was significant risk of harm posed, and it was serious and amounts to misconduct.

In relation to Charges 9a, 9b and 10, given the experience of Mr Kanu and the vulnerability of those patients that he was looking after, the panel found that this breach of fundamental tenets of the nursing profession was serious. The panel found that Mr Kanu's actions fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel concluded that, Mr Kanu's actions in the charges found proved, taken together or individually, amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Kanu'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 and to maintain professional boundaries. 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 recognised that as set out in Mr Kanu's NMC context form and reflective accounts, personal factors may have had an impact at the time of the incidents. However, this was only made known to colleagues at the time of the termination of his contract.

Regarding insight, the panel considered that Mr Kanu has shown limited insight in his reflective accounts. The panel determined, that whilst Mr Kanu has developing insight, it is clear from his reflective account and the NMC context form that he has not yet developed sufficient good insight to demonstrate that he will not repeat the matters of concern.

The panel was satisfied that the misconduct in this case is capable of being addressed. Mr Kanu's behaviour did not demonstrate a deep-seated attitudinal problem, and he appeared open to training and guidance. The panel carefully considered the evidence before it in determining whether or not Mr Kanu has taken steps to strengthen his practice. The panel took into account that Mr Kanu has completed reflections and has shown some awareness of what he needed to remedy and articulated some steps he would take to address the issues, however, he has not provided sufficient detail of any further training or learning he would undertake.

The panel concluded that limbs a), b) and c) of the *Grant* test were engaged in this case. The panel finds that vulnerable patients and members of the public were put at risk and

there was serious potential risk of harm as a result of Mr Kanu's misconduct. The panel determined that Mr Kanu's misconduct had breached the fundamental tenets of the nursing profession, as demonstrated by the breaches of the Code, and therefore brought its reputation into disrepute.

The panel was not satisfied that Mr Kanu can practice safely as he put vulnerable patients and members of the public at risk of harm. It noted that there was no evidence before it about what Mr Kanu is currently doing. The panel concluded that although Mr Kanu has shown some insight, there remains a real risk of repetition. Therefore, it decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required to uphold proper professional standards and maintain public confidence in the profession. It determined that given the findings of misconduct, the public would lack confidence in Mr Kanu's ability to practise safely and effectively.

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

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC.

Submissions on sanction

Ms Ghotra, on behalf of the NMC, drew the panel's attention to an aggravating factor in this case. She submitted that Mr Kanu's conduct put vulnerable patients at risk of serious harm.

Ms Ghotra next drew the panel's attention to a mitigating factor in this case. She submitted that Mr Kanu [PRIVATE], at the time of the incidents.

Ms Ghotra invited the panel to impose a suspension order for a period of six months with review. She submitted that the seriousness of this case requires temporary removal from the register. She further submitted that a suspension order would sufficiently protect the patients and uphold public confidence in nurses and professional standards.

Ms Ghotra submitted that in light of the nature and seriousness of the concerns, the two least severe possible sanctions namely, no further action or a caution order, would not be appropriate. She submitted that no further action would not protect the public interest as it would risk undermining the public confidence in the profession and the regulator. It would not be appropriate to impose a caution order given that the harm was not at the lower end of the spectrum.

Ms Ghotra submitted that although some of the concerns are remediable, they are of a serious nature and Mr Kanu has shown only limited insight. A conditions of practice order

would not adequately address the seriousness of this case, and it is not proportionate nor the appropriate sanction in this case.

Ms Ghotra submitted that a striking off order would be disproportionate in this case.

Decision and reasons on sanction

Having found Mr Kanu'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 accepted the advice of the legal assessor.

The panel took into account the following aggravating features:

- The vulnerability of patients
- Mr Kanu's conduct put patients and public at risk of serious harm

The panel also took into account the following mitigating features:

- Mr Kanu has shown some insight and provided some level of reflections
- There was no evidence of deliberate intention
- Mr Kanu's personal circumstances

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 Mr Kanu's practice would not be appropriate in the circumstances. The SG states

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

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

- *Patients will not be put in danger either directly or indirectly as a result of the conditions.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature and gravity of the charges in this case. It determined that conditions are not sufficient to manage the risks identified.

Furthermore, the panel concluded that the placing of conditions on Mr Kanu's registration would not adequately address the seriousness of this case and would not protect the public and maintain confidence in the profession.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. It found that Mr Kanu has shown awareness

of the seriousness of the misconduct, is open to learning and further training and the panel was satisfied there was no evidence of deep-seated attitudinal issues.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Kanu'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 Mr Kanu. 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 six months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case may be assisted by:

- Mr Kanu's attendance at any review hearing.
- Evidence of completing training around medicines management and the appropriate completion of patient records.
- Evidence of completing training in understanding the principles relating to the reporting of incidents, duty of candour and professional boundaries.

- Written reflections with specific regard to duty of candour and professional boundaries.
- Any relevant testimonials.

This will be confirmed to Mr Kanu 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 Mr Kanu's own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Ghotra. She made an application for an interim order for a period of 18 months, on the same basis as the suspension order the panel has imposed on the grounds of public protection and the wider public interest in order to cover the potential appeal period in this case if an appeal is made.

The panel accepted the advice of the legal assessor.

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 allow for the possibility of an appeal to be made.

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

That concludes this determination.