Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 18 March 2024 – Friday 22 March 2024
Monday 25 March 2024 – Wednesday 27 March 2024
Monday 2 December 2024 – Friday 6 December 2024
Monday 6 January 2025 – Friday 10 January 2025
Friday 7 March 2025
Monday 24 November 2025 – Wednesday 26 November 2025

Virtual Hearing

Name of Registrant:	**Patience Munashe Makamba-Ndongwe**
NMC PIN:	11E0949E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – (September 2011)
Relevant Location:	Liverpool
Type of case:	Misconduct
Panel members:	David Crompton (Chair, Lay member) Pamela Campbell (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	Gillian Hawken (18 – 22 and 25 – 26 March 2024) Fiona Barnett (27 March 2024) Oliver Wise (2 – 6 December 2024, 6 – 10 January 2025, 7 March 2025 and 24 – 26 November 2025)
Hearings Coordinator:	Shela Begum (18 March 2024 – 7 March 2025) Peaches Osibamowo (24 – 26 November 2025)
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter (18 March 2024 – 7 March 2025) Represented by Alastair Kennedy (24 – 26 November 2025
Miss Makamba-Ndongwe:	Partially present and represented by Neomi Bennett (18 March 2024 – 7 March 2025) Not present and not represented (24 – 26 November 2025)
No case to answer:	Charges 1b, 2c(ii) and 4

Facts proved:	Charges 1a, 1c, 1d, 1e, 2a(i), 2a(ii), 2b(i), 2b(ii), 2c(i) and 3
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1. On the 12-13 November 2018 nightshift, in respect of Resident B's concern, failed to:
    a. Contact the Police,
    b. Contact Resident B's next of kin,
    c. Seek medical attention for Resident B,
    d. Escalate the concern to the on-call manager,
    e. Hand over the incident form to the nurse coming on the morning shift,
2. On the 4-5 June 2021 nightshift, in respect of Resident A:
    a. Failed to ensure Resident A's antibiotics were:
        i. collected,
        ii. administered,
    b. Failed to carry out detailed observations, in that you did not:
        i. Check Resident A's vital signs,
        ii. Identify Resident A's deteriorating condition,
    c. Recorded in the patient notes that:
        i. You contacted 111 for antibiotics,
        ii. You were advised to commence antibiotics at 12:00 on 5 June 2021,
3. Your conduct at charge 2.c.i was dishonest, in that you intended for anyone reading Resident A's notes to believe that you had contacted 111 regarding antibiotics, when this had already been done before your shift began,
4. Your conduct at charge 2.c.ii was dishonest, in that you intended for anyone reading Resident A's notes to believe that their antibiotics were not to be administered until 12:00 on 5 June 2021, when they had been prescribed to be administered on 4 June 2021,

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

Background

You have been a registered nurse since September 2011.

In November 2018, while working at [PRIVATE] (the Service), you were responsible for a night shift during which a resident raised a serious concern, alleging that a staff member had assaulted her and stolen money. Although you completed an incident form, it is alleged that you failed to take appropriate action. Specifically, it is alleged that you did not contact the police, contact the resident's next of kin, seek medical attention for the resident, escalate the concern to the on-call manager, or hand over the incident form to the nurse coming on the morning shift. You admitted in a disciplinary meeting that you had not followed the NMC code regarding patient safety. While the allegations made by the resident were unsubstantiated, your failure to act allegedly led to your dismissal from the Service on 13 February 2019.

In or around February-March 2021, you began working at [PRIVATE] Nursing Home (the Home), a 30-bed mental health nursing home. On the night shift of 4-5 June 2021, you were the nurse in charge of the shift and providing care to Resident A, who had an infected wound on her ankle and appeared unwell. The resident was prescribed antibiotics, and it was noted during handover that you were to ensure that the antibiotics were collected from the pharmacy and closely monitor her condition. However, despite being reminded to collect the antibiotics, it is alleged that you failed to do so. When you spoke with Witness 4 during a routine phone call, you allegedly did not mention any concerns about Resident A’s condition, only reporting a flood in a bathroom and as a result Witness 4 assumed that you had administered the antibiotics as previously discussed. The following morning, during the handover, you informed Witness 1 that you had neither sent anyone to collect the antibiotics nor attempted to contact the pharmacy. Witness 1 arranged for a carer to collect and administer the antibiotics and later expressed concern that Resident A might be developing sepsis. Resident A was transferred to the hospital, where she was treated for sepsis but passed away on 12 June 2021.

It was later alleged that you had falsified nursing records, claiming that you had contacted NHS 111 regarding the antibiotics, when this had already been done before your shift. The records also allegedly falsely stated that you had been advised to start the antibiotics at 12:00 on 5 June 2021, when they had already been prescribed for administration on 4 June 2021. As a result of the investigation into the incident, a safeguarding concern was raised, and the DBS placed you on both the children's and adult's lists in April 2022. Your employment at the Home was terminated in June 2021 following a probationary review.

Decision and reasons on application under Rule 31 to admit documentation into evidence

The panel heard submissions from Ms Bennett who made an application under Rule 31 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) to admit documentation into evidence. She submitted that the case at its heart is more than the specific actions of a nurse. It is about the principles and the standards to which the nursing profession is held.

Ms Bennett informed the panel that the document which she is requesting to be put before the panel is called '*let's make it all apparent and transparent'*. She submitted that this document is very relevant and that it is a lighthouse that will guide the panel through a sea of complexity and ambiguity. She stated that this document would illuminate the key issues at stake here and shine light on issues that are not yet known to this panel and the wider community.

Ms Bennett submitted that you find yourself at a crossroads where the decision of the substantial hearing will resonate far beyond these walls. She submitted that this is not just about the fate of a single nurse but that it is about setting a precedent that will echo in nursing homes across the UK. She stated that it is a culmination of lived experiences and a treasure trove of evidence meticulously gathered and presented by a witness called by you whose credibility she said is intact.

Ms Bennett stated that to disregard this important document, would be to turn a blind eye to a resource that could profoundly influence the understanding of the issues

being explored here by the NMC. She emphasized that admitting this document into evidence does not in any way prejudice the NMC, and it is firmly believed by you that the content of the documentation would provide a fair and balanced view and contribute to a more thorough and just evaluation of the facts.

Ms Bennett submitted that the goal here is not to tip the scales unfairly but to ensure that they are adequately balanced with comprehensive and relevant information. She stated that the essence of justice is not just in the application of law, but in the pursuit of truth, and this document does not just contain facts, it narrates a story of the lived experiences of the unheard voices of those who tried to speak out sooner but were silenced as guardians of justice.

Ms Bennett submitted that there is a duty, a solemn responsibility, to ensure that every relevant piece of evidence is considered, that every stone is turned. She stated that the admission of this document is not just a procedural formality, it would be a stride towards a verdict that is key to unlocking the truth in this case.

Ms Bennett informed the panel that the document is a whistleblowing document about certain things pertaining to the Home. She submitted that there is relevant information within the document that is pertinent to the allegations being made against you. She submitted that one particular page of the document is relevant but it seems that the page alone could not be put before the panel. She told the panel that there is information about Resident A included within the document and that it would be a really useful document that the panel can draw on and understand from a different angle.

In response to a question from the panel asking why the document was not introduced at a stage when the witnesses were being cross examined, Ms Bennett responded that although the document was sent to her prior to this date, she had not read it in detail. She informed the panel that after having read the document once again, she realised that there is relevant information within it that is important for the panel to see. She apologised for not having presented it earlier.

The panel heard submissions from Mr Malik. He objected to the document being admitted into evidence and submitted that the document is inadmissible on the basis that it is an unfair document on the basis that the NMC had not previously seen it and it is being produced at such a late stage.

Mr Malik submitted that it is unknown to the NMC how long you have had the document and that it has never been provided to the NMC and to admit the document at this stage in proceedings, when the NMC's witnesses have already concluded giving their evidence, would be unfair.

Mr Malik submitted that the document is not dated, there are no signatures shown on it and whilst there may be some relevance, it also raises matters which are not relevant to the considerations of this case. He submitted that the document includes details that are not being considered by this panel.

Mr Malik submitted that the document details personal issues between colleagues at the Home. He submitted that this was not a whistleblowing document, it was more a statement from someone complaining about some of the NMC's witnesses. He further submitted that there were patient names included in the document which had not been redacted.

Mr Malik submitted that if this document was to be introduced into the hearing, it should have been at an earlier stage so that matters could have been put to the witnesses as they have a right to respond to allegations against them. He submitted that the NMC's witnesses gave evidence for lengthy periods of time and that most of that time was for cross-examination during which he said that Ms Bennett '*assassinated their characters'.*

Mr Malik submitted that there is not a satisfactory answer to why this document was not provided to the NMC or to the panel earlier. However, he submitted that the admission of this document can be made fair and that the only way to do that would be to recall the witnesses named within the document and put the matters raised in the document to the witnesses themselves and give them an opportunity to answer the questions put to them.

The panel accepted the advice of the legal assessor who referred to Rule 31.

The panel first addressed the relevance of the document. It noted that both parties agreed on its relevance and, after careful consideration, concluded that it indeed met the criteria for inclusion. The document is a document about the Home, which pertains to the dates surrounding the incident involving Resident A. It also references two witnesses, whose evidence the panel has already heard, and contains information relevant to Resident A's care.

The panel then turned to the question of fairness in admitting the document. It expressed concern that the document was presented at a very late stage and appeared to address issues related to two NMC witnesses who had not been cross-examined on the specific matters raised. Both advocates suggested that the contents of the document could be seen as undermining or casting doubt on the credibility of these witnesses, who have not yet had an opportunity to respond in light of this. While the panel had not yet seen the document in its entirety, it acknowledged that its contents could influence the assessment of evidence already presented.

After careful consideration, the panel concluded that the fairest course of action in these circumstances would be to admit the document into evidence. It recognised that in order to address the issues raised by the document fairly, it was necessary to recall the two NMC witnesses referenced within it. This would provide an opportunity for them to be cross-examined on the new matters brought to light. The panel was satisfied that recalling these witnesses would safeguard fairness for both parties, ensuring that any potential impact of the document on the proceedings could be fully explored.

In light of these considerations, the panel found it just and appropriate to admit the document, on the condition that the two NMC witnesses will be recalled for cross-examination. Therefore, Ms Bennett's application to admit the document is granted.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Bennett that there is no case to answer in respect of all of the charges. This application was made under Rule 24(7).

Ms Bennett invited the panel to find that there is no case to answer in respect of all of the charges. She submitted that the allegations against you are unsubstantiated and are rooted in systemic workplace racism, implicit bias, and managerial failings. Ms Bennett further submitted that your conduct was far from being negligent or unprofessional and instead reflects adherence to professional standards despite working within an inequitable and discriminatory environment.

Ms Bennett submitted that there has been unequal treatment of you in comparison to a '*white colleague'*, Witness 1. She stated that Witness 1's significant omissions were overlooked. Ms Bennett made assertions of managerial practices such as favouritism, racial othering, and scapegoating, which she said disproportionately targeted you.

Ms Bennett submitted that systemic racism within the workplace was acknowledged by witnesses and reflected broader discrimination faced by black nurses. She submitted that procedural failings, including interruptions of critical questioning and inequitable investigation processes, marginalised your defence. She stated that there was a lack of credible evidence linking your actions to the alleged failures, with critical omissions occurring outside your control.

Ms Bennett noted that, under cross-examination, Witness 4 admitted that there was a deeply entrenched culture of racism in the workplace but asserted that she had played no part in it. Ms Bennett submitted that this admission established the presence of systemic racism in the workplace and that Witness 4's failure to acknowledge her role or take proactive measures to combat this toxic culture underscores her complicity in sustaining it. She stated that Witness 4's defensive stance, combined with her actions towards you, demonstrated how biased managerial decisions and the framing of the allegations reflected systemic racism.

Ms Bennett pointed out that Witness 1's testimony reflected implicit bias and perpetuated harmful stereotypes. For example, she stated that Witness 1 criticised you as someone who *"did not care and could not be bothered*," which Ms Bennett said aligned with societal stereotypes about black workers being lazy or indifferent. She argued that such language shaped how your professional conduct was framed, undermining fairness.

Ms Bennett referred to what she said were instances of Witness 4's attempts to deflect accusations of racism by referencing Witness 1's gifts, such as chocolates and flowers, given to staff, including you. Ms Bennett argued that these acts of favouritism were selective and contributed to workplace divisions, positioning certain individuals, including you, as different or requiring extra validation. She submitted that Witness 1 later scapegoated you, using unfounded criticism to deflect from her own failings. She submitted that this dynamic revealed how favouritism and scapegoating operated in tandem.

Ms Bennett also submitted that Witness 1's significant omissions, such as delaying care escalation for Resident A, were excused, while you were disproportionately scrutinised for systemic issues beyond your control. She submitted that you were subjected to racial othering, being treated as inherently less competent and different. For instance, she submitted that Witness 1 assigned the task of collecting antibiotics to you despite your lack of resources and inability to leave the premises, while white care assistants were not assigned similar tasks. She submitted that you were portrayed as negligent and careless, while similar or worse failings by Witness 1 were overlooked.

Ms Bennett also referenced what she deemed to be Witness 1's implicit bias. She stated that Witness 1 criticised you for not acting on an obvious urgency despite her own failings to document or communicate the urgency. She submitted that statements such as *"I don't think she cared at all"* revealed racialised assumptions that were unsupported by evidence, influencing the framing of the allegations and the scapegoating of you.

Ms Bennett submitted that you faced disproportionately harsh treatment during the NMC investigation, contending that historical allegations from 2018, which had been resolved with no findings of misconduct, were selectively included to prejudice the panel, causing undue stress and reputational harm. She submitted that critical questioning about systemic racism and bias were interrupted or dismissed by the panel. Ms Bennett argued that this dismissal reflected institutional discomfort with addressing systemic racism and undermined your ability to present a full defence.

Ms Bennett further alleged that there were procedural failings, stating that attempts to address issues of bias were repeatedly curtailed. She submitted that the panel dismissed important questions, such as those regarding the witnesses' equality, diversity, and inclusion training. She submitted that despite the relevance of this training in understanding whether the witnesses' actions or perceptions were influenced by unconscious bias or systemic racism, the panel deemed such questioning too broad or unfocused.

Ms Bennett submitted that when she probed the witnesses' actions for potential racial bias, the panel intervened, deeming the question *"overly broad*" and advising her to narrow it down. This approach, she argued, disregarded the cumulative and often subtle nature of systemic racism. She stated that her efforts to establish patterns of behaviour were mischaracterised as "*browbeating"* the witness, which she said undermined the critical importance of addressing repetitive systemic patterns, especially in cases of racial discrimination.

Ms Bennett pointed out that the inclusion of the 2018 allegations, which had been resolved with no adverse findings, was prejudicial and contrary to the principles of procedural fairness. She argued that reintroducing these resolved issues served no legitimate purpose and created an undue burden on you to defend yourself against matters that had already been addressed.

In relation to Resident A's deterioration, Ms Bennett submitted that the allegations were based on the assumption that your actions caused Resident A’s deterioration. However, she submitted that the evidence showed that critical failings occurred outside your control. She stated that you had provided a thorough handover at the

end of your shift, noting that Resident A was stable and clearly communicated the need for antibiotic collection. Ms Bennett submitted that Witness 1 delayed escalating care despite observing Resident A's worsening condition and failed to reassess the patient's care plan following a fall earlier in the week, which could have prevented the deterioration.

Ms Bennett submitted that Witness 1's failure to ensure adequate care and monitor Resident A's pressure sore was a critical omission. She submitted that the sore, which had been documented in the care plan, was not properly treated, contributing to Resident A's condition. Furthermore, Ms Bennett argued that Witness 1's delay in escalating care, including her failure to call 999 for emergency services sooner, directly contributed to Resident A's deterioration. She also pointed out the failure to monitor Resident A's vital signs and the delay in administering antibiotics, which exacerbated her infection.

Ms Bennett submitted that Witness 1's actions were emblematic of systemic failings within the Home. She argued that Witness 4's failure to provide adequate supervision and support enabled Witness 1's neglectful behaviour, and that the safeguarding referral was disproportionately targeted at you while excusing Witness 1's critical failings. This, Ms Bennett submitted, reflected systemic racial bias.

Ms Bennett concluded by urging the panel to exclude the 2018 allegations, as they were irrelevant and prejudiced your case. She argued that the allegations were based on racial stereotyping and scapegoating, which were deeply entrenched in the workplace culture. She invited the panel to consider the broader context of systemic racism, implicit bias, and unequal accountability within the workplace and regulatory process.

Finally, Ms Bennett referred the panel to relevant case law, including *PSA v NMC* (2017), which emphasised the duty of the NMC to thoroughly investigate all potential evidence. She also referenced *Duthie v NMC* [2012] EWHC 3021 (Admin), *Ogbonna v NMC* [2010] EWCA Civ 1216, *Raheem v NMC* [2010] EWHC 2549 (Admin), *Lambert Simpson v HCPC* [2023] EWHC 481 (Admin), *Lusinga v NMC* [2017] EWHC 1458 (Admin), *El-Karout v NMC* [2019] EWHC 28 (Admin) and

Watters v NMC [2017] EWHC 1888 (Admin), which reinforced the importance of contemporaneous notes, fairness, proportionality, and the consideration of mitigating factors in any decision regarding sanctions.

Ms Bennett concluded that the evidence unequivocally demonstrates there is no case to answer. The panel, she submitted, must recognise these dynamics to ensure a just outcome for you and prevent similar injustices in the future.

In Ms Bennett's supplementary submissions, she referred to the NHS '*Just Culture Guide'* and the NMC's Independent Culture review. She highlighted parts of the document which addressed issues relating to discrimination and concerns raised with the NMC about its culture and external pressures particularly in respect of underrepresented groups. She referred the panel to parts of the document which she submitted were relevant to the panel's consideration.

In relation to this application, Mr Malik provided written submissions prior to Ms Bennet's oral submissions in which he stated:

1. *'It is submitted on behalf of the Nursing Midwifery Council ("the NMC') that there is case to answer on all charges: 1,2,3,4.*

2. *In accordance with Rule 24 (7) of the Nursing and Midwifery Council (Fitness to Practise Rules) 2004, it is submitted that the NMC has adduced 'sufficient evidence' such that a properly directed panel could find the facts proved.*

Approach

3. *The relevant authority is the case of R v Galbraith [1981]1 WLR 1039.*

'…when considering whether there is a case to answer, the Panel should first determine whether there is any evidence upon which a Panel could properly find the charges proved. Where there is none, the Panel should find no case to answer (Limb 1).].
Where there is some evidence presented, the Panel should consider the nature and strength of that evidence and decide whether it can properly be relied upon

to find the facts proved. Evidence which is inherently weak and vague, or inconsistent with the remaining evidence in the case, ought not be relied upon (Limb 2)].

4. *The NMC invite the panel to consider the NMC's guidance on Evidence (DMA-6) which includes guidance relating to 'no case to answer' and provides as follows:*

   There may be situations where, at the close of our case, the nurse, midwife or nursing associate feels that we just haven't put forward enough evidence to mean they still have a case to answer.

   There will be no case for a nurse, midwife or nursing associate to answer where, at the close of our case, there is:

   1. no evidence

   2. some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, midwife or nursing associate, or the nurse, midwife or nursing associate's fitness to practise being found to be impaired.

   The question of whether there is a case to answer turns entirely on our evidence. Evidence which might form part of the nurse, midwife or nursing associate's case will not be taken in to account.

   Where the strength or weakness of our evidence depends on the weight it should be given, a submission that there is no case to answer is likely to fail. That issue is best considered after all the evidence has been heard.

5. *The Panel is not reaching conclusions on the facts at this stage, it is solely considering whether, on proper application of the approach set out in Galbraith, it could find any of the contested charges proved.*

6. *The application is brought under the second limb of Galbraith, on the basis that some of the witnesses have provided inherently weak evidence. Further, on an assessment of the evidence presented by the NMC and the evidence of the witnesses, taking the NMC's case at its highest, the Committee properly directing themselves could not find the allegations proved.*

7. *The NMC submit that the correct approach under the second limb of Galbraith is as follows: 'Where the strength or weakness of the prosecution case depends on the view to be taken of a witness's reliability or other matters generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury properly directed, could come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury'*

8. *The NMC submits that the correct approach is for the case to proceed and for the panel to consider any inconsistencies in the witness's evidence after the panel has heard all of the evidence.*

9. *The NMC submits that there is a case to answer and the NMC has presented sufficient evidence to find the facts proved in relation to all 4 charges. The panel are invited to dismiss the submission of no case to answer and allow the case to proceed.*

Submissions

10. *It is submitted that the witnesses have given credible, reliable and consistent evidence. It has been suggested that [Witness 4] and [PRIVATE] are not credible witnesses. The panel at this stage do not have to consider credibility of a witness but it may be worth noting, as to the reliability of the evidence, whether the witnesses would be untruthful in the accounts given and if they are mistaken in their accounts, consideration may be given to the fact that they are giving evidence some 4 years after the incidents occurred and sometimes without the benefit of documentation available to them which may have been closer to the time of the incidents.*

Charge 1

On the 12-13 November 2018 nightshift, in respect of Resident B's concern, failed to:

a) ***Contact the Police,***
b) ***Contact Resident B's next of kin,***
c) ***Seek medical attention for Resident B,***
d) ***Escalate the concern to the on-call manager,***
e) ***Hand over the incident form to the nurse coming on the morning shift,***

11. *[Witness 3], at paragraph 8 of his statement sets out:*

    "…Following that, the nurse should contact the police, the local authority safeguarding team and the resident's family members. The Nurse should also contact as many potential witnesses as possible to gather further information.

    In terms of handover, I would expect the nurse to complete an incident form and immediately contact the on-call manager to explain the situation. The incident should also be handed over to the nurse on the next shift."

    At paragraph 15 of his statement, he sets out:

    "When I asked patience why she did not contact the police, next of kin or seek medical attention for Resident B, she said that 'something just cropped up and I forgot".

12. *[Witness 3] is very clear in his statement that Patience acknowledged that she made an error in failing to highlight the safeguarding to the incoming nurse during the handover on 14 November 2018. "Patience confirmed that she was fully aware of the reporting procedure and agreed that the oncoming nurse may have assumed that all safeguarding actions had been completed by Patience as she did not hand over any actions. She agreed that she did not*

communicate effectively to her colleagues and that thus caused a delay in action"

13. *At exhibit [Witness 3], disciplinary meeting notes, dated 31 January 2019, the Registrant confirms that she did not contact the police, next of kin or seek medical attention following the incident. Furthermore, the Registrant accepts that she forgot to escalate the concern and did not highlight the safeguarding to [PRIVATE].*

14. *[Witness 3] was consistent with what he said in oral evidence. The panel will recall him say "if it was an allegation of a sexual nature, yes police would be called". In oral evidence he confirmed that "She also had the training and she should have followed the safeguarding policy".*

15. *It was put to the witness whether there were any issues with racism at the home and the he confirmed "there was no issues with racism at the home"*

16. *The NMC submits that [Witness 3] has been clear, concise and consistent in what he says in relation to this charge. It is submitted, that the panel can rely on what he says.*

17. *[Witness 3] does not demonstrate an inherent weakness in his evidence and can be relied on. The evidence is such that, taken at its highest, charge 1 is capable of being found proved.*

Charge 2

On the 4-5 June 2021 nightshift, in respect of Resident A:

- ***a. Failed to ensure Resident A's antibiotics were:***
  - ***i. collected,***
  - ***ii. administered***
- ***b. Failed to carry out detailed observations, in that you did not:***
  - ***i. Check Resident A's vital signs***
  - ***ii. Identify Resident A's deteriorating condition***

c. Recorded in the patient notes that:

i. You contacted 111 for antibiotics

ii. You were advised to commence antibiotics at 12:00 on 5 June 2021

18. *The panel heard evidence from [Witness 2] in relation to this charge. The panel were told by [Witness 2] that she was working the night shift on 4 June 2021. [Witness 2] sets out at paragraph 7 of her statement that "I cannot recall the exact times, but before 10pm I had reminded Patience three times about picking up the prescription for Resident A. I recall telling her that she could send one of the carers out to pick it up by using the taxi service that the Home had on account. Patience repeatedly said that she would do it in a minute" Furthermore, she states "When I explained that I rang and the Pharmacy was shut, Patience said she would handover the prescription collection to the next shift". We heard from [Witness 2] in oral evidence that they had enough staff to collect the prescription and that the Taxi will take carers wherever they wanted to go as long as it was work related. We heard that there was a notice on the wall of the office which gives the telephone number for the taxi company and the password for the account. Further, in oral evidence [Witness 2] said she didn't pick the prescription up because she was waiting for the Registrant to tell her as she obeys what the nurse in charge tells her to do.*

19. *The panel also heard from [Witness 1], at paragraph 12 of her statement sets out "I recall that Patience was present in the room when I received the call from 111 to confirm that the prescription of antibiotics was ready to collect from the pharmacy…. I told her to send a carer in a taxi to pick up the prescription." Furthermore, she states "I was not comfortable leaving the prescription to be collected the next morning and I made it clear to Patience that Resident A needed to start the antibiotics as soon as possible"*

20. *[Witness 1] says that Patience agreed that she would make sure the prescription was collected. As the nurse on duty, it was the Registrant's responsibility to ensure the required medication was obtained which it clearly*

wasn't. Exhibit 2 clearly states that the antibiotics were ready to be collected from Tesco pharmacy. [Witness 1] confirms "I immediately sent a carer to collect the prescription for Resident A from the pharmacy. Once they had bought back the prescription pack, I administered the antibiotics to Resident A at 10am".

21. *[Witness 4] in her statement at paragraph 13 states "[Witness 1] informed me that Resident A was not very well due to a wound on her leg and that she had discussed her concerns with an out of hours doctor on 111 who had prescribed antibiotics for her.[Witness 1] stated that the prescription had been sent to the pharmacy that we use for out of hours prescriptions and that she was going to handover the collection of the prescription to the night nurse. Patience, as she was informed that the prescription was ready to collect during the handover" [Witness 4] further states, that "During the same phone call I spoke to Patience, who was coming onto shift as the night nurse, and told her to ensure she picked up the antibiotics and kept a close eye on Resident A."*

22. *It is submitted therefore that there is sufficient evidence presented and that the evidence is neither inherently weak or vague. The evidence, taken at its highest is capable of proving the charge 1 a.*

23. *[Witness 1] confirms in her statement at paragraph 21 that she would have expected Patience to administer the antibiotics to Resident A, to check on her hourly and to record this in the daily care report with details of any changes in her condition. This has not been documented in the daily care notes, Exhibit 1.*

24. *Furthermore, [Witness 1] confirms that Resident A's condition had deteriorated on the morning on 5 June 2021 "the infection had tracked up her leg. I knew this because on 4 June the red area of skin was confined to her ankle, but 5 June the red area had increased to the skin further up her leg." This has been documented in the daily care notes by [Witness 1].*

25. *Additionally, [Witness 4] at paragraph 25 states " I had the opportunity to review the documentation relating to Resident A. By examining at the documentation,*

I could tell Patience had not monitored Resident A during the night of 4 June 2021 because no observations chart had been completed for Resident A. The nurses use an observations chart to document observations for a resident who is identified to be unwell. They would monitor their vital signs every two hours and record them on this chart." [Witness 4] confirms the same as [Witness 1] that she would expect the see notes documenting the observations in the resident's daily care report. [Witness 4] says the daily care notes are the only place where a nurse would document changes in a resident's condition. [Witness 4] confirmed that two hourly checks on Resident A is standard practice for all residents. These checks do not include vital signs observations and often the resident is asleep while the carer checks on them. They are therefore not detailed observations that allow the condition of a resident to be closely monitored.

26. *Furthermore, [Witness 2] at paragraph 11 states that she recalls seeing the Registrant check on Resident A, a few times during the shift, however, she did not know if this was a visual check only or if the Registrant recorded observations. From the evidence it is clear that no observations were recorded. There was nothing in the notes about Resident A's vital signs or any notes to suggest the Registrant had identified Resident A's deteriorating condition.*

27. *Taken at its highest, the evidence is such that charge 2b could properly be found proved.*

28. *In relation to charge 2 c, the panel heard from [Witness 1]. At paragraph 29 of her witness statement sets out "Patience recorded that she rang 111 regarding Resident A during her shift. When I read this, I did ask myself why she did that as there was no reason to because we had already agreed to send a carer out for the prescription at 7.40pm on 4 June 2021". The note can be seen on Exhibit [Witness 1]/01.*

29. *[Witness 4] states at paragraph 26 "I noticed that Patience had recorded on 4 June 2021 that she called 111 and that they agreed to send a prescription to be picked up the next day and administered at 12pm. I thought this was very*

unusual because a doctor would not prescribe antibiotics but recommend that they are not started straight away. In my opinion, this would never happen."

30. *Furthermore, [Witness 4] said that there was no need for the Registrant to contact 111 as [Witness 1] had already done this during her shift, as per the records she made in the daily care notes and handover diary. [Witness 4] confirms that she asked the Registrant whether she had contacted 111 to arrange the prescription "Patience stated that she may have made an error with the daily care notes when she recorded that she called 111." Exhibit [Witness 4]/04 (Notes of probationary review meeting dated 14 June 2021.)*

31. *Both witnesses [Witness 4] and [Witness 1] have been clear, concise and consistent in their witness statements, local statements and in oral evidence. [Witness 4] and [Witness 1] do not demonstrate an inherent weakness in their evidence and they both can be relied on. The evidence is such that, taken at its highest, charge 2 c is capable of being found proved.*

<u>Charge 3 and 4</u>

Your conduct at charge 2.c.i was dishonest, in that you intended for anyone reading Resident A's notes to believe that you had contacted 111 regarding antibiotics, when this had already been done before your shift began.
Your conduct at charge 2.c.ii was dishonest, in that you intended for anyone reading Resident A's notes to believe that their antibiotics were not to be administered until 12:00 on 5 June 2021, when they had been prescribed to be administered on 4 June 2021.

32. *Both charges 3 and 4 are dishonesty charges. When considering these charges, the panel should adopt in its approach the test for dishonesty laid out in the case of Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club) [2017] UKSC 67:*

'What was the defendant's actual state of knowledge or belief as to the facts; and was her conduct dishonest by the standards of ordinary decent people?'

33. *The NMC guidance 'Making decisions on dishonesty charges and the professional duty of candour' reference 'DMA-8', last updated 27 February 2024 Any dispute over whether a nurse, midwife or nursing associate behaved dishonestly means that the panel's findings will depend on what conclusions they can draw about the nurse, midwife or nursing associate's state of mind from the basic facts. To help the panel focus on the central issues and be able to express this in their reasoning; it needs to consider the following:*

    what the nurse, midwife or nursing associate knew or believed about what they were doing, the background circumstances, and any expectations of them at the time whether the panel considers that the nurse, midwife or nursing associate's actions were dishonest, or whether there is evidence of alternative explanations, and which is more likely.

34. *The panel do not need to ascertain at this stage what the Registrant's actual state of knowledge or belief was to the facts and decide whether her conduct with that state of mind would be considered dishonest by the standards of ordinary decent people. The Panel is not reaching conclusions on the facts at this stage, it is solely considering whether, on proper application of the approach set out in Galbraith, it could find any of the contested charges proved. It is submitted that these charges are best considered after all the evidence has been heard.*

35. *The panel have heard live evidence from 4 witnesses as well as documentary evidence. It is submitted that the evidence is not weak, vague or inconsistent with other evidence, pursuant to Galbraith. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.*

36. *The panel heard from [Witness 1] who said that there was no reason for the Registrant to record that she rang 111 because she had already agreed to send a carer out for the prescription at 7.40pm on 4 June 2021. [Witness 4] says that she thought this was very unusual and, in her opinion, this would*

never happen. Exhibit [Witness 4]/04 clearly shows that the Registrant stated that she may have made an error with the daily notes when she recorded that she called 111.

37. *[Witness 4] and [Witness 1] have been consistent in their evidence. The documentary evidence before the panel support what both witnesses say. There evidence does not demonstrate an inherent weakness and they both can be relied on. The evidence is such that, taken at its highest, charge 3 and 4 are capable of being found proved.*

Conclusion

38. *The NMC submit that there is sufficient evidence presented and that the evidence is neither inherently weak or vague. Therefore, there is a case to answer.*

39. *The NMC submits that there was harm caused to a patient and if allegations were proved fall far below the standard expected of a nurse and would amount to serious professional misconduct.*

40. *The NMC submit that adopting a proper approach and taking into account all of the evidence at this stage, the evidence taken at its highest, all 4 charges could properly be found proved, and the panel are invited to dismiss the submission of no case and allow the case to proceed."*

Mr Malik supplemented these written submissions with brief oral submissions to which Ms Bennett responded in her supplementary submissions.

The panel took account of the submissions made and accepted the advice of the legal assessor, who advised the panel to give careful consideration to each word of each charge.

The panel carefully considered the submissions from Ms Bennett that there is no case to answer on all of the charges based on claims of racial discrimination by

witnesses in this case and also institutional unfairness at an organisational level. The panel also took into account the documents referred to by Ms Bennett in support of her submissions, namely '*The NMC Independent Culture* Review' and '*The NHS Just Culture Guide'.*

The panel is completely independent of the NMC. The panel is aware that its role is to make decisions in cases brought before it. In doing so it should be aware of the potential effects of unconscious bias when reaching any decisions.

The panel considered that at this stage of proceedings its role is to apply the *Galbraith* test. It should assess the evidence presented in respect of the allegations and consider whether these allegations are supported by credible testimony and documentary evidence. In addition, in light of the submissions made by Ms Bennett, the panel considered whether the evidence before it indicates a pattern of disparate treatment that could amount to racial discrimination to a degree which renders the evidence either inherently weak or insufficient.

The panel noted that much of the witness evidence in the case is corroborated by documents completed contemporaneously or alternatively, by interviews which were conducted shortly after the events alleged. After careful consideration it did not consider this to be evidence which indicated racial or institutional bias. As a result, the panel took the view that at this stage of the process, it was appropriate to assess the evidence on its own merits.

At the current stage of the hearing, there has been no witness evidence called by you and any case based on racial discrimination and institutional unfairness would be reliant on Ms Bennett's cross examination of the NMC's witnesses. The effect of that cross examination, combined with Ms Bennett's submissions, in the panel's judgment, did not give rise to such a loss of credibility as would be required to undermine the witnesses' evidence such that they could not be relied on at this stage of the case.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented to make out the charge.

Charges 1a, 1c, 1d and 1e

The panel noted that the evidence that was relied upon by the NMC in respect of charges 1a, 1c, 1d and 1e included Witness 3's oral testimony, his written statement and the documentary evidence including disciplinary meeting notes from 31 January 2019 and the handover sheet for the relevant dates.

In respect of these charges, the panel noted that Witness 3's evidence, both oral and documentary, set out the duty of care on you as the nurse in charge of the shift to fulfil the actions as set out in the charges. The panel noted that his evidence also set out that the actions required to be taken were set out in the policy and that you were aware of the policy and reporting procedures in such circumstances. It further noted that the NMC relied on Witness 3's evidence which outlined the expectations for a nurse in charge in these circumstances and maintained that the proper conduct expected would include contacting the police, the on-call manager, seeking medical attention and conducting a proper and thorough handover.

The panel noted that the disciplinary meeting notes from 31 January 2019 reflected that you admitted to failing to contact the police or seek medical attention.

The panel applied the first stage of the *Galbraith* test and concluded that there is evidence that would allow a panel to conclude that the charge could be proved. It noted that the second stage of the *Galbraith* test requires assessing whether the evidence is so weak or lacking in substance that no reasonable panel could find a case to answer. Taking into account Witness 3's evidence and the documentary evidence which included recorded admissions by you at a local level, the panel determined that the evidence is not so weak or contradictory as to warrant dismissal at this stage.

Therefore, having applied the *Galbraith* test, the panel concluded that there is a case to answer in respect of charges 1a, 1c, 1d and 1e. The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Charge 1b

In respect of charge 1b, the panel noted that the evidence before it included Witness 3's oral testimony and written statement, which set out that the next of kin had not been contacted by you. It took into account that Witness 3's evidence was that, in such circumstances, where a vulnerable mental health patient is raising such allegations, a next of kin should have been contacted. The panel noted that Witness 3's written statement indicated that when asked by him why you did not contact the next of kin, you responded, *"something just cropped up and I forgot".* The panel noted that this evidence sets out that you did not contact the next of kin.

However, the panel recognised that the evidence relied upon by the NMC does not establish whether a next of kin was identifiable or contactable in these circumstances. The panel concluded that there was a degree of uncertainty within the evidence before it regarding the availability of a contactable next of kin. While it could be inferred that a next of kin was available, given that no such argument was presented, the panel was not satisfied that such an inference, standing alone, was sufficient to substantiate the charge.

At this stage, the panel found that there was insufficient evidence to confirm that there was in fact a next of kin who was contactable in the circumstances. Therefore, the panel considered whether the charge could be dismissed solely on the basis of this uncertainty.

In applying the second stage of the *Galbraith* test, the panel assessed whether the evidence was so weak or lacking in substance that no reasonable panel could find a case to answer. The absence of clear evidence regarding the existence or ability to

contact a next of kin meant that the charge could not be proved on the basis of the evidence. As a result, the panel concluded that, in the absence of clear evidence, there was no realistic prospect of finding charge 1b proved, and therefore, there was no case to answer in respect of charge 1b.

Charges 2a (i) and (ii)

In respect of charges 2a (i) and (ii), the panel considered the evidence relied upon by the NMC in support of these charges, which included the written statements of Witnesses 1 and 2.

The panel noted that the NMC relied on Witness 2's evidence who maintained that she had reminded you multiple times before 22:00 on the 4 – 5 June 2021 nightshift about collecting Resident A's prescription for antibiotics. Witness 2's written statement sets out that, despite her repeated reminders, you told her that you would collect it "*in a minute"* and, later, that you would pass the task on to the next shift after being informed that the pharmacy was closed.

The panel noted that the NMC relied on Witness 1 in respect of this charge whose evidence supported the assertion that you were aware of the urgency of the prescription. Her evidence noted that when the call came in from 111 confirming that the antibiotics were ready, she had told you to arrange for a carer to collect the prescription immediately. Witness 1's evidence, as relied on by the NMC, informed the panel that when she arrived for her shift on the morning of 5 June 2021, she realised that the prescription had not been collected and that she had immediately arranged for a carer to collect the prescription from the pharmacy.

The panel considered whether the evidence provided was sufficient to establish that you failed to ensure the antibiotics were collected and administered as required. It took into account that Witness 2's statement and oral evidence suggests that you were repeatedly reminded of the need to collect the prescription and failed to take appropriate action. Additionally, Witness 1's statement and oral evidence sets out that you were directly informed of the prescription's availability and instructed to send a carer to collect it but that this was not actioned.

In applying the first stage of the *Galbraith* test, the panel concluded that there is evidence for a reasonable panel to find that the charge is capable of being proved. In applying the second stage of the *Galbraith* test, the panel assessed whether the evidence was so weak or lacking in substance that no reasonable panel could find a case to answer. The panel considered that the evidence, as presented by both Witness 1 and Witness 2 did not display significant contradictions that would render it inherently weak.

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, based on the evidence before it, it was not prepared to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Charges 2b (i) and (ii)

In respect of charges 2b (i) and (ii), the panel noted the evidence before it, which included statements from Witnesses 1, 2 and 4.

The panel noted that the NMC relied upon the evidence of Witness 4. Witness 4's evidence set out that a detailed observations chart for Resident A had not been completed during the night shift of 4 June 2021. Her evidence set out that such a chart is essential for documenting vital signs and tracking the condition of a resident identified to be unwell. Her evidence also set out that the practice of checking vital signs every two hours is standard procedure for residents who are unwell, and without a chart, it appeared that no monitoring had taken place. The panel noted that the NMC was advancing the argument that a lack of recorded observations in the documentation suggested that Resident A's condition was not closely monitored, and any deterioration was not identified in a timely manner.

The panel noted that the NMC further relied on Witness 2's evidence who suggested that although you may have checked on the resident a few times throughout the shift there was no clear indication that these checks involved detailed observations that

were documented, nor was there evidence that Resident A's deteriorating condition was noted.

The panel took into account that the NMC further relied on Witness 1's evidence who outlined a clear deterioration in Resident A's condition, noting that the infection on 5 June 2021 had spread further up the resident's leg. This deterioration had been documented in the daily care notes by Witness 1 but the NMC argued that despite this, no corresponding documentation from you was found to indicate that you had noticed or recorded any signs of deterioration during your shift.

In applying the first stage of the *Galbraith* test, the panel concluded that there was evidence for a reasonable panel to find that the charge is capable of being proved. The panel noted that the NMC has provided evidence from multiple witnesses which included statements regarding the failure to carry out detailed observations and monitor vital signs.

In applying the second stage of the *Galbraith* test, the panel assessed whether the evidence was so weak or lacking in substance that no reasonable panel could find a case to answer. The evidence presented included the testimonies of Witnesses 1, 2 and 4 supported the claim of inadequate monitoring and a failure to identify a deteriorating condition. The panel concluded that it did not observe any significant contradictions, weaknesses or vagueness to warrant dismissal of the charges at this stage. The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Charges 2c (i)

In respect of charge 2c(i), the panel noted the evidence relied upon by the NMC which included Witness 4's written statement, oral evidence and the records from the probationary review meeting. The panel noted that Witness 4's evidence was that there was no need for you to contact 111, as this had already been done by Witness

1 earlier on 4 June 2021 and that this had been documented in the daily care notes as well as the handover diary. It noted that Witness 4's evidence further set out that she asked you whether you had contacted 111 to arrange the prescription, to which you replied that you may have made an error when recording this action in the daily care notes.

In applying the first stage of the *Galbraith* test, the panel found that there was evidence for a reasonable panel to conclude that the charge is capable of being proved. In applying the second stage of the *Galbraith test*, the panel assessed whether the evidence was so weak or lacking in substance that no reasonable panel could find a case to answer. The evidence presented, particularly Witness 4's statement and your admission at a local level of an error in the documentation, is not contradicted by any other evidence.

Therefore, the panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Charge 2c(ii)

In respect of charge 2c(ii), the panel considered the evidence relied on by the NMC was that of Witness 4's written statement and the relevant notes for Resident A. Witness 4's written statement indicated that she noticed a record in Resident A's notes stating that you had called 111 and that they agreed to send a prescription for antibiotics to be administered at 12:00 on 5 June 2021. Witness 4's evidence expressed concern about the timing of this, stating that it was unusual for a doctor to prescribe antibiotics without recommending that they be started immediately.

However, the panel noted that the patient notes did not contain any record completed by you that explicitly stated you were advised to commence antibiotics at 12:00 on 5 June 2021, as alleged in the charge. The panel found that there was no clear evidence in the patient records to support this assertion.

In applying the first stage of the *Galbraith* test, the panel found that the evidence before it did not establish that had recorded in Resident A's notes that you were advised to commence the antibiotics at 12:00 on 5 June 2021. The panel therefore concluded that the evidence to support charge 2c(ii) did not meet the threshold required to proceed. As a result, the panel determined that there was no case to answer in respect of charge 2c(ii).

Charge 3

To assess whether there is a case to answer in respect of charge 3, the panel applied the *Galbraith* test to evaluate the evidence and determine whether a reasonable panel could conclude that the charge is likely to be proved.

The panel noted that the evidence to support this charge included the written statements from Witness 4, who explained that you had recorded in the patient notes that you contacted 111 regarding antibiotics, despite this action already having been completed by another nurse before your shift began. Witness 4's evidence informed the panel that when questioned about the discrepancy, you indicated that you may have made an error in your notes.

The panel considered that charge 3 alleges dishonesty in respect of your actions at charge 2c(i) and it would need to consider, if charge 2c(i) is found proved at the facts stage, whether you had intentionally misrepresented the notes with the purpose of misleading others into believing you had contacted 111. The panel noted that within the documentation there has been an explanation provided by you that could be suggestive of an innocent mistake rather than a deliberate attempt to deceive.

The panel considered whether the evidence is sufficient to allow a reasonable panel to conclude that you acted dishonestly. While the evidence suggests there was a misrepresentation in the patient notes, the panel found it necessary to consider whether this misrepresentation was intentional and whether it was designed to mislead.

In light of the available evidence, which includes your acknowledgment of a potential error and Witness 4's statement regarding the prior actions taken by another nurse, the panel concluded that there is sufficient evidence to suggest that the charge is capable of being proved. Therefore, the panel concluded that there is a case to answer in respect of charge 3. The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Charge 4

The panel noted that charge 4 alleges dishonesty in relation to your actions under charge 2c(ii). Given that the panel has determined there is no case to answer in respect of charge 2c(ii), charge 4 is therefore dismissed.

Decision and reasons on application to admit hearsay evidence

On day 14 of the hearing, after the panel had heard evidence from Witness 5, Ms Bennett made an application for the written statement of Witness 6 to be admitted into evidence as hearsay. She submitted that Witness 6's statement is a critical piece of evidence which should be included in the case as she submitted that it is essential for a fair assessment of the case against Miss Makamba-Ndongwe. She referred to the witness statement prepared by Witness 6, a former colleague of the Miss Makamba-Ndongwe at [PRIVATE] nursing home.

Ms Bennett submitted that, while it is acknowledged that Witness 6 was not present on the specific day of the alleged incidents, her statement is necessary for understanding the broader context within which these allegations have arisen. The environment at [PRIVATE] nursing home, as alleged by Witness 6, was one marked by systemic mismanagement and racial bias, particularly under the leadership of Witness 4. Ms Bennett highlighted that Witness 6 alleged a pattern of behaviour by Witness 4, which included favouritism towards certain staff based on their ethnic background, excessive scrutiny of black staff, and a toxic workplace culture. She

stated that this atmosphere left employees, including the Miss Makamba-Ndongwe, vulnerable to unfounded accusations.

Ms Bennett further submitted that Witness 6's insights into the operational failures at the nursing home, such as the lack of clear policies on prescription collection and unsafe staffing practices, are crucial for understanding the circumstances that led to the allegations against Miss Makamba-Ndongwe. Ms Bennett emphasised that the relevance of the statement lies not in the specific events of the day in question, but in the ongoing and pervasive issues at the nursing home, which created an environment ripe for misunderstandings and mismanagement.

Ms Bennett submitted that it is essential to consider these factors when evaluating the allegations against Miss Makamba-Ndongwe. She argued that to ignore this context would be to overlook potential systemic failures that may have contributed to the situation. Furthermore, Ms Bennett stated that the principles governing fair hearings support the inclusion of Witness 6's statement and excluding it would not only compromise the integrity of the proceedings but would also undermine the panel's ability to make an informed decision based on the full spectrum of relevant facts.

Ms Bennett submitted that, in accordance with the principles of natural justice and the precedents set by cases such as *Ladd v Marshall* and *Bonhoeffer v GMC* [1954] EWCA Civ 1, the panel should admit Witness 6's statement as evidence to ensure that the hearing adheres to the highest standards of fairness.

Ms Bennett concluded by urging the panel to allow Witness 6's statement to be introduced into evidence, as this would ensure that the panel has a more comprehensive understanding of the dynamics at [PRIVATE] nursing home. She submitted that the witness statement is not merely supplementary, but fundamental to a thorough and just examination of the case. Ms Bennett stressed that it highlights the need to consider how systemic and managerial failures can disproportionately affect staff and lead to unjust outcomes.

Ms Bennett requested that the panel consider the statement as essential evidence, pivotal for ensuring a fair process.

Ms Bennett confirmed that the reason for the application being made at this stage was due to Witness 6 having a medical matter that prevented her from giving evidence today. She explained that Witness 6 had agreed to give evidence today, but due to her medical condition, she was unable to do so.

Ms Bennett further submitted that Witness 6 had stated she would try her best to attend tomorrow but that her attendance was not guaranteed. Given this uncertainty, Ms Bennett explained that the application was being made as a precautionary measure, to avoid holding up the proceedings unnecessarily. She emphasised that she had spoken to Witness 6, who had confirmed that she would try her best to attend the next day. Ms Bennett stated that the aim was to avoid prolonging the hearing if Witness 6 was unable to attend.

Mr Malik submitted that he objected to the inclusion of the statement on the grounds that it was not relevant or fair. He pointed out that the witness clearly stated in her statement that she was not present on the day of the incident. Mr Malik submitted that the statement primarily speaks about contextual matters, but the witness was not present at the time of the alleged events and, therefore, cannot assist the panel with the charges Miss Makamba-Ndongwe is facing.

Mr Malik further submitted that the statement included multiple instances of hearsay, with references to another colleague who had not been called to give evidence. He highlighted that the panel did not know who this individual was, nor had they heard from her. Mr Malik also noted that the allegations in the statement had not been put to Witness 4. He reminded the panel that the defence had ample opportunity to submit this statement in advance but had failed to do so.

Mr Malik submitted that the witness also mentioned an incident where Witness 4 allegedly sent her home without arranging safe transport. He argued that this matter was not relevant to the charges and questioned how this statement could assist the

panel in determining whether the charges against Miss Makamba-Ndongwe were proven or not.

Mr Malik concluded by submitting that there is a strong public interest in the expeditious disposal of this case. He reiterated that the witness statement was not fair or relevant and, therefore, invited the panel not to admit it into evidence.

The panel accepted the advice of the legal assessor.

The panel carefully considered the application for the admission of the written statement of Witness 6. In doing so, it took into account the submissions of both Ms Bennett and Mr Malik.

Firstly, the panel considered the relevance of the statement. While the statement is not directly relevant to the specific facts of the case, as Witness 6 was not present during any of the incidents as charged, it may be relevant to the broader context. Although the statement may not be directly tied to the specific incidents in question, the statement speaks to alleged systemic issues and the workplace culture.

The panel also considered the fairness of admitting the statement. The panel noted that the statement is not signed or dated, this witness was not present during the events alleged in the charges, and that if the statement is admitted into evidence as hearsay the NMC would be deprived of the opportunity to cross-examine the witness on her statement. However, the panel notes that the matters raised in the statement are of a similar nature to allegations made by another witness, and Mr Malik, on behalf of the NMC, had the opportunity to cross-examine that witness. This provides the panel with confidence that the core issues of systemic mismanagement and workplace environment have already been sufficiently explored, and the failure to cross-examine this particular witness would not unduly prejudice the NMC.

In weighing these considerations, the panel concluded that the statement, although limited in nature, does offer context to the case and contributes to a fuller understanding of the environment at the nursing home. It is important for the panel to consider all factors that may have influenced the events leading to the allegations,

including systemic and cultural issues, even if they do not directly relate to the specific charges. The panel concluded that admitting the statement would ensure a fair and balanced assessment of the case, taking into account all relevant factors.

In light of the above, the panel decided to admit the statement of Witness 6 into evidence. It was the panel's view that doing so would not compromise the fairness of the proceedings, particularly given the opportunity already provided to explore similar matters through cross-examination of other witnesses.

Decisions and reasons to adjourn the hearing until the next day to facilitate your giving evidence

On day 15 of the hearing, Ms Bennett informed the panel that you had intended to attend the virtual hearing but were unable to do so due to unforeseen circumstances. She explained that [PRIVATE] had interfered with your phone, which contained all the necessary passwords for your emails and other accounts and that this had led to difficulties being able to get into contact with you. As a result, your phone required repairs, leaving you without the means to access the hearing.

Additionally, Ms Bennett outlined your difficult personal situation, noting that you are [PRIVATE]. She explained that you have [PRIVATE] with health conditions, and this requires you to be at home and available in case of an emergency. Ms Bennett further explained that, due to your [PRIVATE] preventing you from joining the hearing via phone. She also mentioned that you were [PRIVATE] and that, in your current state, you would not be able to give evidence, although you very much wish to do so. In light of these challenges, Ms Bennett requested an adjournment to allow you to give evidence at a later time. She offered to travel from London to [PRIVATE] to assist you in using her computer to join the hearing and provide your testimony. Alternatively, Ms Bennett suggested that you could attend the NMC hearing offices in Stratford, London, to give evidence in person.

Mr Malik addressed the panel in response to these matters. He urged the panel to progress with the hearing, highlighting the significant delays faced in the hearing thus far. He submitted that it was in the public interest for these matters to be dealt

with in a timely manner and as such the panel should not grant an adjournment particularly given the allowances extended to Ms Bennett by the panel up until now.

The panel accepted the advice of the legal assessor.

The panel carefully considered the submissions made by both parties in relation to the request for an adjournment. It took into account the explanations provided by Ms Bennett regarding the unforeseen circumstances that prevented you from attending the hearing, including the technical difficulties you experienced, your [PRIVATE], and the personal challenges you are facing. The panel also noted the impact these factors may have had on your ability to give evidence effectively at this time.

The panel acknowledged the concerns raised by Mr Malik regarding the significant delays in the proceedings and the importance of ensuring the timely resolution of the matter in the public interest. However, the panel also recognised the fundamental importance of fairness and ensuring that you are given a reasonable opportunity to present your evidence.

Having considered all the information before it, the panel has decided to grant the adjournment. This will allow you the opportunity to provide your best evidence. The panel also considered the most effective course of action. It considered whether it would be possible to hold the hearing in person at the NMC's London hearing centre. The panel considered that this was not a viable option at this stage, not only due to the potential unavailability of all participants but, more importantly, because, as highlighted by Ms Bennett, you provide care for [PRIVATE] require you to be at home and available in case of an emergency. As such, the panel decided to allow a period of adjournment for the rest of day 15 of the hearing, with a view to recommencing the hearing on day 16 when Ms Bennett has had an opportunity to make the arrangements she proposed to facilitate your giving evidence at this hearing.

Decisions and reasons to allow Witness 6 to give live evidence

Having agreed to the decision to adjourn the hearing, Ms Bennett raised a subsequent matter relating to her earlier hearsay application in respect of Witness 6.

On day 15 of the hearing, the panel revisited the issue of allowing Witness 6 to give live evidence after Ms Bennett explained that unforeseen and unavoidable health matters had prevented her attendance the previous day. The panel had already admitted Witness 6's written statement as hearsay on day 14, acknowledging its potential relevance in providing context to the broader workplace issues at [PRIVATE] nursing home, despite the witness not being present during the incidents in question. Given the urgency of concluding the hearing within the remaining four days, and the desire to avoid further delays, the panel considered the importance of maintaining the progress of the proceedings. It acknowledged the NMC's invitation to keep the hearing moving forward but decided that allowing Witness 6 to give evidence live may assist the panel in understanding the systemic failures at the nursing home. This decision was in line with its earlier ruling, where the panel determined that the inclusion of Witness 6's statement, while not directly addressing the allegations, was necessary to provide a complete context for the case. Thus, the panel decided to allow the witness to give evidence in the hearing, whilst remaining mindful of the earlier decision to admit her statement and the limited time available to conclude the hearing.

Decision and reasons on facts

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

- Witness 1: Registered General Nurse, [PRIVATE] Nursing Home

- Witness 2: Carer, [PRIVATE] Nursing Home

- Witness 3: Home Manager, [PRIVATE] Services (at the time of the incident)
- Witness 4: Home Manager, [PRIVATE] Nursing Home (at the time of the incident)

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

- Witness 5: Carer, [PRIVATE] Nursing Home (at the time of the incident)
- Witness 6: Agency staff member, [PRIVATE] Nursing Home (at the time of the incident)

The panel also heard evidence from you.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Malik on behalf of the NMC and by Ms Bennett. The panel took note of Ms Bennett's submissions that you have been the victim of racism, disproportionate scrutiny and bias. However, during your evidence you said that you did not consider yourself to have been a victim of racism and that you denied there was a culture of racism in the Home. Despite this, the panel was alert to the possibility of racism or victimisation and it recognised that it was possible for somebody to be a victim of racism without acknowledging it themselves. However, after reviewing all of the evidence, the panel was satisfied that the evidence against you was based on objective facts rather than racist attitudes.

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.

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

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

Considerations on charge 1

During your evidence, there were several instances where you appeared to confuse two separate incidents: one involving a staff member and a resident and another involving two residents. The NMC has always been clear that the charge against you related to an incident involving a staff member and a resident and not an incident between two residents. Further, within the documentation before the panel, the evidence specifically sets out that the charge relates to an allegation relating to an incident between a resident and a staff member. For instance, the Disciplinary Letter dated 10 December 2018 makes this clear, stating;

> *'On 14.11.2018, you have completed an Incident Form stating that you were aware a resident had alleged that she had been raped by a member of staff, and that this member of staff had stolen money from her.'*

The panel was mindful that the documents relied upon had been sent to you and Ms Bennett. It considered that all of the documentary evidence, and the live evidence relating to this charge, related to that of an allegation of an incident between a staff member and a resident. Whilst the panel noted your confusion, it concluded that this did not impact upon the matters detailed in the charge. It considered that the entirety of charge 1 specifically concerns your alleged failure to properly follow procedures in relation to the concerns raised by Resident B. In its approach to deciding on the limbs of charge 1, the panel took into account the documentation which included an incident report written by you and witness statements, which consistently identified

allegations made by Resident B against a staff member. The panel raised this discrepancy with you directly during your evidence and sought to clarify your understanding. It considered your evidence in relation to this charge but was mindful that it could only place limited weight on this as you appeared to be describing a different incident, unrelated to this specific charge despite having responded to questions about the staff member and resident incident in your local interview. In conclusion, the panel considered your confusion regarding the specific details of the incident should be noted, but the focus remains on your failure to follow procedures, particularly concerning the failure to escalate concerns appropriately and provide proper medical attention in relation to the charge in question.

Charge 1a, 1c, 1d, and 1e

1. On the 12-13 November 2018 nightshift, in respect of Resident B's concern, failed to:
    a. Contact the Police,
    b. […]
    c. Seek medical attention for Resident B,
    d. Escalate the concern to the on-call manager,
    e. Hand over the incident form to the nurse coming on the morning shift,

These charges are found proved.

In reaching this decision, the panel took into account the documentary and oral evidence from Witness 3, the local disciplinary meeting notes, and your evidence.

The panel took into account that Resident B was known to make frequent false allegations. However, as Resident B was a vulnerable adult, the panel determined that your duty was to take all allegations seriously in accordance with safeguarding principles. The panel referred to its earlier considerations that:

> *"In respect of these charges, the panel noted that Witness 3's evidence, both oral and documentary, set out the duty of care on you as the nurse in charge of the shift to fulfil the actions as set out in the charges. The panel noted that*

his evidence also set out that the actions required to be taken were set out in the policy and that you were aware of the policy and reporting procedures in such circumstances. It further noted that the NMC relied on Witness 3's evidence which outlined the expectations for a nurse in charge in these circumstances and maintained that the proper conduct expected would include contacting the police, the on-call manager, seeking medical attention and conducting a proper and thorough handover."

In addition, as the nurse on duty, and as accepted by you during the Service's disciplinary meeting, you had responsibility to take appropriate actions in response to the concerns raised by Resident B. Having established the existence of this duty, the panel proceeded to examine whether there was a failure on your part in relation to these charges.

The panel had regard to the Service's handover sheet dated 13 November 2018 and in relation to Resident B, it was recorded by you that:

"Resident B made allegation that [PRIVATE] [..] came into her room and raped her and stole her money"

The panel noted that this record of the allegation was consistent with the NMC's case that the allegation related to a resident and a staff member rather than a resident-on-resident allegation.

The panel had regard to the Disciplinary Invitation letter dated 10 December 2018. The author of this letter was Witness 3 and within the document, he stated:

'it is alleged that you did not escalate this matter by contacting the Police, the local authority safeguarding team, seek medical attention for the resident or contact a member of the Management Team.
It is further alleged that you did not make the nurse coming on duty on the next shift aware of the specific nature of the allegations made by the service user, and of any action that needed to be taken'

The panel also had regard to the Disciplinary Meeting notes dated 31 January 2019 where it is noted that when Witness 3 asked you:

> *'The first allegation is that you not contacting the police […] or seek medical attention for [Resident B] following the incident? Can you tell me more about this?"*
>
> You responded: *"Something just cropped up and I forgot'*

You were also asked why you ticked the form suggesting that you had informed the on-call manager when that had not been the case and you responded:

> *'I informed the nurse at the handover and meant to escalate it but forgot'.*

The panel noted that during his evidence, Witness 3 stated that Police and local authority safeguarding should have been contacted immediately in respect of the concern raised by Resident B. His evidence informed the panel that when allegations of a sexual nature were raised, the Service's standard safeguarding protocols required immediate escalation. This was consistent with his written statement in which he stated:

> *'Patience knew Resident B very well and should have known to take all of her allegations seriously. [PRIVATE] also had a safeguarding policy that all staff were aware of. I no longer have access to the policy. Patience would have been fully aware of this policy and had completed the relevant training. She had been working at [PRIVATE] for years and knew the processes and the residents. There was no reason for her not to properly safeguard this incident'*

The panel noted that within your written statement you referred to an incident which you believed to have occurred between two residents. You stated that based on your professional judgment and prior knowledge of Resident B's history of making false allegations, you believed the claim to be unfounded. You stated that instead of contacting the police or seeking medical attention for Resident B, you reported the incident to a senior Clinical Nurse the following morning and that you believed this

was an appropriate response given their seniority and familiarity with Resident B's pattern of behaviour. You further acknowledged that you did not escalate the allegation to the on-call manager but reiterated that you informed another more senior Clinical Nurse whom you considered capable of handling the matter.

The panel considered your argument that you were unsure of the procedure and did not have immediate access to a written policy. However, the responses you gave during the disciplinary meeting contradicted this. When asked what steps you would take if you were in a similar situation, you responded, *"See if they were OK, write an incident form, contact the police, Safeguarding and highlight it in the handover".* During this meeting you suggested that, as it was your shift, you accepted that it would have been your responsibility to take action following an incident and your responses demonstrated that you were aware of the protocol to be followed in such circumstances. Additionally, disciplinary records show that there was no documented attempt to seek guidance from a senior colleague regarding the correct action to take.

In relation to charge 1a, the panel determined that, based on both your own local admissions and the evidence presented by the NMC, you were aware of the protocol requiring police involvement but did not follow it. As such, the panel concluded that you did fail to contact the police in response to the concern raised by Resident B.

In relation to charge 1c, the panel heard from Witness 3, that in such circumstances medical intervention was necessary and that it was a mandatory safeguarding step. The panel noted that during the Service's disciplinary meeting you responded that you had forgotten when asked why you did not seek medical attention for Resident B following the concerns raised by her. The panel considered whether your failure stemmed from a misunderstanding of your responsibilities but concluded that safeguarding protocols require all allegations of this nature to be taken seriously and responded to appropriately. Witness 3's testimony confirmed that all staff were expected to seek medical attention in cases where abuse was alleged, to ensure both the physical well-being of the resident and the proper documentation of any injuries. His evidence further confirmed that all staff were aware that in cases of alleged sexual abuse, medical professionals should be involved promptly. Given the

nature of the concerns raised by Resident B, the panel found that this was a failure in your duty of care. The panel determined that medical attention was necessary regardless of the perceived credibility of the allegation, as per standard safeguarding procedures. Additionally, the panel noted that the handover sheet in which you recorded the incident reported to you by Resident B did not indicate any action taken by you. As a result, the panel concluded that in response to Resident B's concern, you did fail to seek medical attention.

In relation to charge 1d, the panel considered that the disciplinary records demonstrated that you did not escalate the matter to the on-call manager despite this being a procedural expectation. It noted that during the disciplinary interview, you acknowledged that you understood this was something you should have done and that you failed to do this. The panel heard from Witness 3 that the on-call manager would have been available throughout the shift and would have expected to be informed immediately about an incident of this nature. In light of the evidence before it, the panel concluded that you did fail to escalate the concern raised by Resident B to the on-call manager.

In relation to charge 1e, the panel had regard to the handover notes for the relevant date. As outlined above, the panel noted that you recorded some detail regarding the allegations raised by Resident B about the staff member. However, the panel further noted that during the disciplinary meeting, when asked whether you took the allegation to the handover meeting, you responded *"I wrote it on the handover sheet*". When asked whether the handover sheet should have reminded you to raise this to the oncoming shift during the handover, you responded "*it should have".* In light of all of the evidence before the panel, it concluded that, whilst some details were recorded by you within the handover note, this did not constitute handing over an incident form to the nurse on the oncoming shift. As a result the panel finds charge 1e proved.

Charge 2a(i) and (ii)

2. On the 4-5 June 2021 nightshift, in respect of Resident A:
    a. Failed to ensure Resident A's antibiotics were:

i. collected,
ii. administered,

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 4 and Witness 2. The panel further took into account your evidence and the evidence provided by Witness 5.

The panel also had regard to Resident A's daily care report. It noted that there was an entry made at 19:00 by Witness 1 which set out that Resident A's condition was worsening, noting that an abscess appears to have developed and recorded symptoms including redness and pain. It was also recorded by Witness 1 that she had contacted the out of hours GP and that she was awaiting a callback from 111. Her entry stated:

> *'Old scab to [PRIVATE] malleolus, and now appears to have developed into query abscess approx 3cms in diameter. Surrounding area red tight and painful … contacted 111 now awaiting call back from OOH GP'*

This was consistent with Witness 1's written statement in which she stated:

> *'During this shift I checked on Resident A in the late afternoon, although I cannot recall the exact time. I observed that Resident A was very lethargic and generally unwell. I examined her and noticed that she had what appeared to be an old wound on her ankle that was most likely a pressure sore. The wound seemed infected to me because it was red and I suspected that it would develop into an abscess. I therefore wanted to start Resident A on antibiotics as soon as possible to prevent the wound from going septic*
>
> *At some point before 7pm, I rang 111 […] I explained my observations of Resident A's wound […] I received a call from 111 at 7:40pm to say that they had sent the prescription and that it was now ready to be picked up.'*

The panel heard in evidence from Witnesses 1 and 2 that the pharmacy was open until 22:00, and that the period between 19:40 and 22:00 provided a timeframe in which the antibiotics could have been collected.

Witness 1 stated:

> *'As Patience was the only trained nurse on duty that evening, I told her to send a carer in a taxi to pick up the prescription. It is common practice at the Home for the nurses to send out carers to collect prescriptions for residents. I was not comfortable leaving the prescription to be collected the next morning and I made it clear to Patience that Resident A needed to start the antibiotics as soon as possible. I informed her that the carer can use the Home's account to pay for the taxi by giving the account password when they call to book the taxi. This procedure was common sense because the nurse on duty cannot leave the Home. Patience agreed that she would make sure the prescription was collected.*
>
> *Patience should have known about this practice as there is a notice on the wall of the office which gives the telephone number for the taxi company and the password for the account to which the journey should be charged. It was the expected practice in these circumstances and I made it clear to Patience during handover that this is the method she should follow. As the nurse on duty, it was her responsibility to ensure the required medication was obtained.*
>
> *I finished my shift at 8pm and left the Home. I was back on shift the next day, 5 June 2021. When I arrived in the morning, the first thing I asked Patience was whether she had started the antibiotics for Resident A. Patience confirmed that she had not administered the antibiotics because she had tried to call [PRIVATE] pharmacy but they had not answered so she had not collected the prescription.'*

Witness 4 stated:

> *'I had taken the weekend of 3 to 4 June 2021 off work because I was going away, however I was still on call as the Home manager. I received a call from*

a day nurse, Witness 1 [PRIVATE] during the handover to the evening shift on 4 June 2021. This would have been between 7:30pm to 8pm. [PRIVATE] informed me that Resident A was not very well due to a wound on her leg and that she had discussed her concerns with an out of hours doctor on 111 who had prescribed antibiotics for her. [PRIVATE] stated that the prescription had been sent to the pharmacy that we use for out of hours prescriptions and that she was going to handover the collection of the prescription to the night nurse, Patience, as she was informed that the prescription was ready to collect during the handover.'

Witness 1 and Witness 4 were consistent with each other, and their oral evidence was consistent with their written evidence.

The panel also heard evidence from Witness 2 who stated that prior to the pharmacy closing she reminded you three times about collecting the antibiotics for Resident A. She also stated that you had access to a taxi service, which could be used for work-related purposes, including collecting prescriptions. She described a notice in the office displaying the taxi service details and a password for the account and claimed that she had informed you about the availability of the taxi service which was consistent with the evidence of Witness 1. She further stated that she eventually called the pharmacy herself, but by that time, it had closed.

Your account of this incident sets out that on the night shift of 4 – 5 June 2021, you were faced with multiple urgent situations, including another resident's deteriorating health and a flood in the Home. You set out that these emergencies impacted your ability to prioritise the collection of Resident A's antibiotics. Additionally, you stated that there were no clear guidelines on how out-of-hours prescriptions should be collected, and you had assumed that the morning staff would be in a better position to pick up the medication. You also mentioned that when the manager, Witness 4, called to check if everything was fine, you responded affirmatively, thinking you still had time to collect the prescription. Although you acknowledged the delay, you stated that the morning staff were informed about the situation during the handover.

The panel noted the evidence of Witness 5 who was also on shift on that date and when asked about whether she recalled a flood in any of the bathrooms, she could not provide a clear recollection of this due to the passage of time.

In light of all of the evidence before it, the panel concluded that you failed to ensure that Resident A's antibiotics were collected. Accordingly, charge 2a(i) is found proved.

In relation to charge 2a(ii), the panel concluded that your failure to collect the antibiotics directly meant that they were not administered as prescribed during your shift.

Therefore, as established in charge 2a(i), the antibiotics were not collected during your shift. As a result, they were not available for administration during the period of your shift. Accordingly, charge 2a(ii) is found proved.

Charge 2b)

2. On the 4-5 June 2021 nightshift, in respect of Resident A:
    b. Failed to carry out detailed observations, in that you did not:
        i. Check Resident A's vital signs,
        ii. Identify Resident A's deteriorating condition,

These charges are found proved.

In reaching this decision, the panel took into account Resident A's daily care notes, the evidence from Witness 4 and Witness 1 and your evidence.

In relation to charge 2b(i), the panel considered whether you conducted detailed observations, specifically by checking Resident A's vital signs. These are understood within the nursing profession to be, as a minimum, blood pressure, temperature, pulse and respirations. It was your duty as nurse in charge of the Home on that night shift to ensure that those observations were carried out.

Witness 2 stated:

> *'During the night shift, the care staff will usually check on each resident every two hours. I recall seeing Patience check on Resident A a few times during our shift because she was unwell. I do not know if this was a visual check only or if Patience recorded observations. Patience asked the carers to check on Resident A every time we passed her room because she was unwell, but she did not comment further on her condition.'*

Witness 4 stated:

> *'In addition to collecting and administering the antibiotics, I would have expected Patience to take observations of Resident A as soon as possible. She could then use this initial set of observations as a 'key performance indicator' which she could compare later observations against to determine whether Resident A's condition was deteriorating or improving. I would then expect Patience to repeat the observations every two hours.*
>
> *Patience should have known how to monitor Resident A because it is standard nursing practice. It was also explained during training.'*

During her evidence, Witness 4 clarified that she reviewed Resident A's documentation and found that no observation chart was completed, and therefore there was no recorded evidence that vital signs were checked. She also stated that for unwell residents, it was standard practice to check and record vital signs every two hours, but no records indicate that this was done in this case.

Witness 1 stated:

> *'If Patience did check Resident A hourly, she did not document this in the daily care notes […] This is the only document where we record changes in a resident's condition.'*

The panel had regard to Resident A's daily care notes for this date and noted that there were no detailed observations or vital checks recorded.

Your account set out that you delegated checks to carers. The panel noted that this was somewhat consistent with Witness 2's evidence that you "*asked the carers to check on Resident A every time we passed her room because she was unwell".* However, the panel was not satisfied that this constituted a detailed observation, specifically checking for vital signs.

As a result of there being no documentation to indicate that vital signs were checked, the panel was satisfied that you did not check Resident A's vital signs.
Accordingly, charge 2b(i) is found proved.

In relation to charge 2b(ii), Witness 1 stated:

> *'I would not describe Resident A as extremely unwell on the morning of 5 June 2021, but her condition had deteriorated. She was still lethargic and the infection had tracked up her leg. I knew this because on 4 June the red area of skin was confined to her ankle, but by 5 June the red area had increased to the skin further up her leg. I documented this in the daily care notes. Resident A was quite a frail lady and I think the wound would have been painful for her.'*

Witness 4 stated:

> *'I had the opportunity to review the documentation relating to Resident A. By examining at the documentation I could tell that Patience had not monitored Resident A during the night of 4 June 2021 because no observations chart had been completed for Resident A. The nurses use an observations chart to document observations for a resident who is identified to be unwell. They would monitor their vital signs every two hours and record them on this chart. This chart is usually found on the resident's file, but I could not see any chart in Resident A's file. If a nurse is too busy to fill out the observations chart I would expect to see notes documenting the observations in the resident's daily care report. Patience had also failed to document observations in the daily care report for Resident A, […]. The daily care notes are the only place where a nurse would document changes in a resident's condition.'*

In your account of events, you stated that Resident A's condition remained stable throughout your shift, with no obvious signs of deterioration. You explained that observations were either conducted by you or delegated to carers when you were occupied with other tasks. You maintained that you were actively monitoring Resident A and had no reason to believe that there was an urgent need for medical intervention at that time. According to your account, you relied on visual assessments and communication with the care team to ensure Resident A's well-being. You did not believe there was a need for additional documentation beyond what was recorded in the resident's notes.

The panel concluded that the absence of recorded deterioration does not indicate that there was no deterioration; rather, it suggests that the necessary checks were not performed to assess Resident A's deteriorating condition overnight. The evidence before the panel confirms that between the 19:00 entry by Witness 1 and the following morning, Resident A's condition had worsened, but there were no detailed observations recorded by you. This demonstrated to the panel that you had not identified Resident A's deteriorating condition overnight.

As a result, the panel concluded that you failed to carry out detailed observations in that you did not identify Resident A's deteriorating condition. Accordingly, Charge 2b(ii) is found proved.

Charge 2c(i)

2. On the 4-5 June 2021 nightshift, in respect of Resident A:
    c. Recorded in the patient notes that:
        i. You contacted 111 for antibiotics,

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, specifically Resident A's daily care notes.

The panel considered your documentation in Resident A's notes. It noted that you made an entry under the label 'night' and recorded:

'Resident A continues to struggle with her bad leg. Contacted 111 Rang back at […] and agreed to send a prescription to [PRIVATE] which […] be picked up tomorrow as [PRIVATE] last night was not answering…'

Accordingly charge 2c(i) is found proved.

Charge 3

3. Your conduct at charge 2.c.i was dishonest, in that you intended for anyone reading Resident A's notes to believe that you had contacted 111 regarding antibiotics, when this had already been done before your shift began,

This charge is found proved.

In its consideration of this charge, the panel took into account all of the documentary evidence and your evidence. In reaching its decision, the panel gave particular regard to the test set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67.*

Witness 1 stated:

'Patience recorded that she rang 111 regarding Resident A during her shift. When I read this, I did ask myself why she did that as there was no reason to because we had already agreed to send a carer out for the prescription at 7:40pm on 4 June 2021.'

The panel considered that Witness 1's account of this was consistent as her entry was marked clearly prior to the entry made by you in which she recorded:

'Contacted 111 now awaiting call back from OOH GP'

During her oral evidence Witness 1 maintained that there was no need for you to contact 111, as the prescription for Resident A had already been confirmed at the start of your shift and a note to that effect had been made in the diary.

Witness 4 stated:

'When reviewing the daily care notes […], I noticed that Patience had recorded on 4 June 2021 that she called 111 and that they agreed to send a prescription to [PRIVATE] pharmacy to be picked up the next day and administered at 12pm. I thought this was very unusual because a doctor would not prescribe antibiotics but recommend that they are not started straight away. In my opinion, this would never happen. Additionally, there was no need for Patience to contact 111 as [PRIVATE] had already done this during her shift, as per the records she made in the daily care notes and handover diary. The 111 receiver would have logged their contact with the Home regarding Resident A and would have a record confirming that the prescription had been given, therefore they would not issue another prescription.'

The panel concluded, based on the evidence before it, it is more likely than not that the prescription had already been confirmed prior to you making your entry in the daily care notes.

You said that you had mistakenly recorded a note stating that you had contacted 111 regarding Resident A's antibiotics. You said that this was an error and that the note was actually meant for another resident who was unwell that night. You explained that you had called 111 about the other resident and were asked to monitor her condition and call back if necessary. The incorrect documentation occurred due to a mix-up in patient notes, and you stated that if those records were available, they would corroborate your account. You emphasised that this was a simple record-keeping mistake and not an intentional misrepresentation.

You firmly denied any intent to mislead regarding the 111 call. You reiterated that the incorrect entry in Resident A's notes was a clerical mistake, not a deliberate attempt to fabricate information. You explained that, due to the busy nature of the shift and the multiple responsibilities you were handling, you had mistakenly documented the call under the wrong patient's records. You maintained that at no point did you intend to deceive anyone and that the confusion was an honest error rather than an act of dishonesty.

The panel considered the actual state of your knowledge or belief as to the facts. The panel heard during evidence that Witness 1 handed over to you that the prescription was confirmed by the out of hours GP and that you were made aware that it was available for collection from a supermarket. The panel also noted that the evidence of Witness 2 was that she had reminded you on more than one occasion that the antibiotics needed to be collected. The panel therefore concluded that you were aware that the prescription for antibiotics had been confirmed at the point of making that entry and that you did not have a reason to contact 111 again in relation to this matter.

The panel carefully considered your account, including your explanation that the incorrect entry resulted from a documentation error rather than an intentional misrepresentation. While it acknowledged the pressures of your shift and the possibility of human error, it ultimately found your explanation, that some elements of the entry were accurate whilst others were not, was inherently implausible and did not align with the available evidence. It therefore could not find a plausible alternative explanation for the entry.

The panel then went on to consider whether, based on your knowledge of the facts, your subsequent actions would be considered dishonest by the standards of ordinary decent people. It concluded that your entry indicating that you had contacted 111 and that you were instructed to collect the prescription the following day was intended to misrepresent the sequence of events and create a misleading impression. The panel concluded that your actions would be considered as dishonest by the standards of ordinary decent people. Accordingly, charge 3 is found proved.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this resuming hearing that although Miss Makamba-Ndongwe had been present at previous hearings, she would not be in attendance at this hearing and that the Notice of Hearing letter had been sent to her registered email address by secure email on 22 October 2025.

Further, the panel noted that the Notice of Hearing was also sent to Equality for Black Nurses (E4BN) who had been representing Miss Makamba-Ndongwe at previous hearings. The panel was informed that E4BN was no longer representing Miss Makamba-Ndongwe and would not be in attendance.

Mr Kennedy, on behalf of NMC, submitted that it had complied with the requirements of Rules 11 and 34.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the dates and times of the resumed hearing, that the hearing was to be held virtually, including instructions on how to join.

In the light of all of the information available, the panel was satisfied that Miss Makamba-Ndongwe has been served with proper notice of the resumed hearing.

Decision and reasons on proceeding in the absence of Miss Makamba-Ndongwe

The panel next considered whether it should proceed in the absence of Miss Makamba-Ndongwe. It had regard to Rule 21 and heard the submissions of Mr Kennedy who invited the panel to continue in the absence of Miss Makamba-Ndongwe. He submitted that Miss Makamba-Ndongwe had voluntarily absented herself from this hearing.

Mr Kennedy submitted that there had been no engagement at all by Miss Makamba-Ndongwe with the NMC in relation to this stage of the proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion. Further, in an email dated 30 October 2025 a representative for E4BN stated that they have *'been unable to establish contact'* with Miss Makamba-Ndongwe.

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 Miss Makamba-Ndongwe. In reaching this decision, the panel has considered the submissions of Mr Kennedy and the advice of the legal assessor. The panel has had regard to the overall interests of justice and fairness to all parties. The main considerations were:

- No application for an adjournment has been made by Miss Makamba-Ndongwe;
- Miss Makamba-Ndongwe has not engaged with the NMC recently and has not responded to any of the letters sent to her about this hearing;
- An email from E4BN, dated 30 October 2025, stated that they have also '*been unable to establish contact'* with Miss Makamba-Ndongwe;
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious concluding of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Miss Makamba-Ndongwe.

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 Miss Makamba-Ndongwe'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, Miss Makamba-Ndongwe's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Kennedy submitted that the panel should have 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.'*

Mr Kennedy 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 Kennedy identified the specific, relevant standards where Miss Makamba-Ndongwe's actions amounted to misconduct.

Mr Kennedy submitted that if the panel decide that Miss Makamba-Ndongwe's behaviour amounts to serious professional misconduct, the panel can move on to the question of impairment as of today.

Mr Kennedy submitted that a number of paragraphs of the code have been breached namely 1.1, 1.2, 1.4, 2.6, 8.3, 8.5, 10.3, 13.1, 17.1, 19.1, 20.1, 20.2 and 20.3.

Mr Kennedy accepted that not all breaches of the Code lead to a finding of misconduct but submitted that Miss Makamba's behaviour fell well below the standards that would be expected of a registered nurse and amounted to misconduct.

Mr Kennedy submitted that the panel may refer to NMC Guidance FTP-12 and consider any contextual factors that may have contributed to her behaviour. He submitted that there was evidence that the Home was extremely busy and Miss Makamba-Ndongwe was required to do multiple tasks simultaneously.

Mr Kennedy submitted that Miss Makamba-Ndongwe's conduct amounted to misconduct as she acted dishonestly, caused harm to a patient and has not shown evidence that she has thought about the impact of her actions.

Submissions on impairment

Mr Kennedy moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kennedy submitted that Miss Makamba-Ndongwe failed to follow policy, ensure treatment was administered, carry out observations, caused harm to one patient and placed another patient at risk of harm. He submitted that she had brought the profession into disrepute and that professional dishonesty is never acceptable. Miss Makamba-Ndongwe's behaviour is not what the public would expect from a registered nurse.

Mr Kennedy submitted that the panel must look at Miss Makamba-Ndongwe's past behaviour and what has happened since these incidents to determine if there is a risk of repetition in the future.

Mr Kennedy submitted that the panel should consider the need to protect the public and the wider public interest. He referred the panel to the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Kennedy submitted that strengthening of practice and insight are important factors that should be considered.

Mr Kennedy submitted that Miss Makamba-Ndongwe denied the charges brought against her and although this is not a factor in determining impairment, it is not clear that she understands the effect of her behaviour on residents, colleagues or the nursing profession. He submitted that if the panel is not satisfied that she understands the impact of her behaviour, then her impairment remains.

Mr Kennedy submitted that Miss Makamba-Ndongwe's behaviour could be remediable, although dishonesty is hard to remediate as it is an attitudinal issue. He submitted that the charges relate to events that took place a number of years ago yet there is no evidence of strengthened practice, therefore, the panel cannot be sure she is unlikely to repeat the conduct found proved. Accordingly, the risk of repetition remains.

Mr Kennedy submitted that Miss Makamba-Ndongwe's actions exposed residents to a risk of harm and actual harm. He submitted that without evidence of strengthened practice a finding of current impairment is required to satisfy public protection.

Mr Kennedy submitted that the public would be appalled to hear that a nurse with such findings against them were allowed to practise unrestricted. He submitted that a finding of impairment would ensure that a nurse does not repeat such conduct and if there were a finding of no impairment it would send the message that it is acceptable for a nurse to act in this manner. Therefore, to uphold public confidence in the NMC and maintain proper standards in the profession, there should be a finding of impairment in the wider public interest.

The panel accepted the advice of the legal assessor.

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 Miss Makamba-Ndongwe's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Makamba-Ndongwe's actions amounted to breaches of the Code. Specifically: 1.1, 1.2, 1.4, 2.6, 8.3, 8.5, 10.3, 13.1, 17.1, 19.1, 20.1 and 20.2.

*'**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:

2.6 recognise when people are anxious or in distress and respond compassionately and politely

8 Work cooperatively
To achieve this, you must:

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.5 work with colleagues to preserve the safety of those receiving care

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:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'

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 charges 1a, 1c, 1d and 1e were found proved in relation to a vulnerable patient who should have been able to rely upon Miss Makamba-Ndongwe as the nurse in charge. Miss Makamba-Ndongwe's failure to escalate serious concerns regarding the alleged theft of the patient's property and their allegation of rape, represented a serious lack of care to the patient and a breach of the policies of the Home.

The panel considered Miss Makamba-Ndongwe's oral evidence and the evidence from the local investigation which indicates that she knew she should have escalated the concerns raised by the patient and there was no good reason why she did not do so. This is sufficiently serious to amount to misconduct.

In relation to charges 2ai, 2aii, 2b, 2c and 3, the panel considered these concerns as one continuous incident. The panel accepted that Miss Makamba-Ndongwe had the primary responsibility to collect and administer the resident's antibiotics, or to ensure that this was done. As the nurse in charge and knowing that this patient was elderly, frail and vulnerable, there was a clear requirement to safeguard the wellbeing of the patient. As a nurse Miss Makamba-Ndongwe would have known that the prompt commencement of antibiotic treatment is important and as she worked on night shifts regularly, she should have known the process for obtaining out of hours medication.

The panel found that Miss Makamba-Ndongwe was reminded several times by fellow staff about the need to collect the medication for the patient. The panel found that Miss Makamba-Ndongwe was seriously at fault for not arranging for the antibiotics to be collected and administered. This was a failure in her duty of care for this patient.

Further, the panel considered that although Miss Makamba-Ndongwe had asked a Healthcare Assistant to check on Resident A, she still had a duty to review the resident's vital signs herself. This is a basic and fundamental nursing responsibility and there is no evidence that she did this or ensured that the resident was being monitored. Miss Makamba-Ndongwe stated that there was a care plan sheet for Resident A, however, the panel did not have sight of this. The panel found that even if there was a care plan sheet, Resident A was not monitored and did not receive the

care they should have had. The panel considered that Miss Makamba-Ndongwe's action in documenting that she had called 111 was intended to mislead. In light of this, the panel determined that the combination of these failings amounted to misconduct.

The panel acknowledged that Miss Makamba-Ndongwe stated that the Home was busy. However, there is no evidence that the Home was understaffed, therefore the panel was not satisfied that this could provide an excuse for her failure to ensure that the patient's antibiotics were collected and administered. Therefore, this amounted to misconduct.

The panel found that Miss Makamba-Ndongwe's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Makamba-Ndongwe'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: 3 March 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 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. At 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.'*

At 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 found that patients were put at risk and were caused physical harm as a result of Miss Makamba-Ndongwe's misconduct. Miss Makamba-Ndongwe's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel determined that the four limbs of the above test are engaged.

The panel considered that Miss Makamba-Ndongwe had either harmed or put at serious risk of harm, two patients (in two different homes). In relation to charge 1, she did not do what was expected of her in reporting the concerns raised by a vulnerable patient who made complaints regarding rape and the theft of their belongings. This put this patient at risk of harm. Further, at the second home, in not ensuring that Resident A received the antibiotics they needed, Miss Makamba-Ndongwe's failure to act caused them actual harm leading to a significant deterioration in their condition.

The panel found that Miss Makamba-Ndongwe's conduct in the facts found proved put the profession into disrepute, breached fundamental tenets of the profession and were dishonest.

Regarding insight, the panel considered that there is no evidence of any insight, remorse or strengthening of practice. It acknowledged that dishonesty is not easily remediable but it can be remediated and there is no evidence that this has been done. Miss Makamba-Ndongwe failed to provide evidence that she has developed any insight.

The panel accepted that it is difficult to address concerns related to dishonesty but it was satisfied that the misconduct in this case is capable of being addressed.

The panel considered that there is no evidence before it to show that Miss Makamba-Ndongwe has taken steps to strengthen her practice or remediate her dishonesty. Consequently, the panel is of the view that there is a risk of repetition. Further, Miss Makamba-Ndongwe has not shown remorse for her conduct and not acknowledged the effect of her behaviour on her patients, colleagues or the nursing profession. Consequently, patients could be put at risk of harm if she were allowed to practise unrestricted. The panel therefore 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 also required because nurses must be trustworthy and the seriousness of Miss Makamba-Ndongwe's misconduct must be marked. An informed member of the public would be shocked if she were allowed to practise unrestricted, given the seriousness of the facts found proved. Therefore, 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 Miss Makamba-Ndongwe's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Makamba-Ndongwe's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Makamba-Ndongwe off the register. The effect of this order is that the NMC register will show that Miss Makamba-Ndongwe has been struck-off the register.

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

Submissions on sanction

Mr Kennedy informed the panel that in the first Notice of Hearing, dated 25 January 2024, the NMC had advised Miss Makamba-Ndongwe that it would seek the imposition of a striking-off order if it found Makamba-Ndongwe's fitness to practise currently impaired.

Mr Kennedy submitted that the purpose of a sanction is not to have a punitive effect, rather it is to address the public protection concerns and satisfy the wider public interest.

Mr Kennedy submitted that the panel should consider any mitigating and aggravating factors in making its decision on sanction. He submitted that mitigating factors may include Miss Makamba-Ndongwe previously engaging in the regulatory process and that she has no previous NMC referrals made against her. He submitted that aggravating features may include a breach of trust, actual harm to a patient, dishonesty and a lack of insight.

Mr Kennedy submitted that the NMC's sanction bid is a striking-off order. He submitted that the panel should start with the least restrictive sanction and go through the possible sanctions until reaching the one it feels is most appropriate. He submitted that taking no action or imposing a caution order would not be appropriate. The clinical issues could possibly be addressed with a conditions of practice order but when combined with the dishonesty, the lack of recent engagement and the lack of remorse, it is submitted that a conditions of practice order would not be appropriate in this case.

Mr Kennedy submitted that Miss Makamba-Ndongwe's removal from the register is necessary in this case and the question is whether this removal should be temporary

or permanent. He referred the panel to NMC Guidance SAN-3d which gives guidance on suspension orders.

Mr Kennedy submitted that Miss Makamba-Ndongwe's conduct raises fundamental concerns about her professionalism. He submitted that confidence in the profession cannot be maintained if she is not removed from the register, and given the attitudinal concerns which have not been remedied, a striking-off order is the most appropriate sanction.

Mr Kennedy submitted that the NMC guidance recognises that not all dishonesty is serious. He referred to the case of *Sawati v GMC* [2022] EWHC 283 (Admin) and submitted that whether the dishonesty is a '*red card'* rather than a '*yellow card'* issue is a matter for the panel to evaluate. He submitted that Miss Makamba-Ndongwe failed to obtain the necessary medication for a resident, then lied about what she did, and that her dishonesty caused harm to the resident. He submitted that this is not on the lower end of the dishonesty spectrum and Miss Makamba-Ndongwe has not expressed remorse for her actions.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Miss Makamba-Ndongwe'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:

- Abuse of a position of trust
- Lack of insight into failings

- A pattern of misconduct over a period of time
- Conduct which caused people actual harm and put people at risk of suffering harm.

The panel also took into account the following mitigating features:

- Previous good character.

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 Miss Makamba-Ndongwe'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 Miss Makamba-Ndongwe's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Makamba-Ndongwe's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature and seriousness of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Makamba-Ndongwe's registration would not adequately address the seriousness of this case and would not adequately protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. Both patients were clearly vulnerable and the panel took into account the significant harm caused to Patient A together with the potential harm to Patient B whose complaints should have warranted a proper investigation.

The panel determined that a suspension order was not appropriate in this case. It was not a single instance of misconduct. There were attitudinal concerns. In addition, Miss Makamba-Ndongwe had shown no insight; and in view of all these matters, there was a significant risk of repeating behaviour. Further, in this particular case, the panel made reference to NMC Guidance and considered that the deliberate breaching of the duty of candour to cover up when something had gone wrong made the dishonesty in this case, coupled with the breach of trust and the vulnerability of the patients involved, put the case towards the higher end of the scale of seriousness.

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. It would not satisfy the public protection concerns and it would not adequately mark the seriousness of the regulatory concerns.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel found that there is a degree of repetition in relation to Miss Makamba-Ndongwe's misconduct as there was an incident in 2018 and another in 2021. It decided that there is an attitudinal issue which is exacerbated by Miss Makamba-Ndongwe's lack of insight, lack of remorse, apportioning of blame to deflect fault and her failure to engage at this stage of the proceedings.

The panel was of the view Miss Makamba-Ndongwe's actions were significant departures from the standards expected of a registered nurse. To allow her to continue to practise would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Makamba-Ndongwe's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to 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.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that the substantive striking-off order will not come into effect until 28 days after the decision is served on Miss Makamba-Ndongwe. Consequently, an 18 month interim suspension order is necessary for the protection of the public and in the wider public interest. He submitted that should there be an appeal, the process could take up to 18 months, as such the order should cover this period of time.

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 considered the position of the Disclosure and Barring Service (DBS) in relation to Miss Makamba-Ndongwe's practice. This does not change the panel's view in relation to the imposition of an interim suspension order. The panel does not know if there has been an update on the DBS's position regarding Miss Makamba-Ndongwe, and in any case, the high threshold for an order to be imposed on the public interest ground has been met.

The panel concluded that an interim conditions of practice order would not be sufficient in this case, due to the reasons already identified in the panel's determination for imposing the substantive order.

The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period.

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

This will be confirmed to Miss Makamba-Ndongwe in writing.

That concludes this determination.