

**Nursing and Midwifery Council
Fitness to Practise Committee**

Substantive Hearing

Monday, 29 September 2025 – Tuesday, 07 October 2025

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

Name of Registrant:	John Uwenluyi Osukporu
NMC PIN:	08G2100E
Part(s) of the register:	Sub part 1 RNMH: Mental health nurse, level 1 16 June 2022
Relevant Location:	Sutton Coldfield Birmingham
Type of case:	Misconduct
Panel members:	Derek Artis (Chair, lay member) Jessica Read (Registrant member) Caroline Ross (Lay member)
Legal Assessor:	Michael Levy
Hearings Coordinator:	Tyra Andrews
Nursing and Midwifery Council:	Represented by Amy Hazlewood, Case Presenter
Mr Osukporu:	Not present and unrepresented at this hearing
Facts proved:	Charges 1a) i), 1a) ii), 1b), 2 and 3
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	Suspension order (12 months)
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Osukporu was not in attendance and that the Notice of Hearing letter had been sent to Mr Osukporu's registered email address by secure email on 28 July 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and venue of the hearing and, amongst other things, information about Mr Osukporu's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Osukporu

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

Ms Hazlewood submitted Mr Osukporu has not engaged with the NMC in relation to proceedings. She outlined the attempts made on the morning of this hearing via telephone in addition to the telephone calls made on 2 April 2025, the emails sent on 10 April 2025 and 4 June 2025 which received no response. Ms Hazlewood

submitted that there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mr Osukporu
- Mr Osukporu has not engaged with the NMC since 10 June 2024 and has not responded to any of the correspondence sent to him via email, letter or telephone about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Witnesses are due to attend and give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Osukporu in proceeding in his absence. The panel noted that the evidence upon which the NMC relies was sent to Mr Osukporu

via email, it also had regard to the numerous attempts made to contact Mr Osukporu, including by telephone at the start of the hearing. It determined that the NMC had made reasonable efforts to contact Mr Osukporu and he had not provided a formal response or engaged with the NMC since 10 June 2024 despite their efforts.

The panel acknowledged that Mr Osukporu will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

Furthermore, the limited disadvantage is the consequence of Mr Osukporu's decision to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge

That you, a registered nurse:

- 1) Between 22 and 23 October 2023 in respect of Resident A
 - a) did not provide care in accordance with Resident A's care plan in that you failed to monitor and/or record adequately, or at all, Resident A's:
 - i) Blood sugar levels
 - ii) Ketone levels
 - b) Failed to escalate Resident A's deteriorating condition

- 2) During your internal interview on 26 October 2023, you told Colleague A and Colleague B that you had checked Resident A's blood sugar levels "at around 10pm prior to giving meds, it was high" or words to that effect, when you had not checked Resident A's blood sugar levels at that time.
- 3) Your actions in charge 2) were dishonest in that you intended Colleague A and Colleague B to believe you had checked Resident A's blood sugar levels at that time when you had not.

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

Background

Mr Osukporu registered as a nurse with the NMC on 26 June 2009. On 2 August 2021, he started working for the Home as a self-employed nurse.

The charges arose in relation to one incident that occurred on the night shift of 22 to 23 October 2023. Witness 1 raised concerns about Mr Osukporu's response to Resident A's clinical deterioration overnight on this shift, which Mr Osukporu was the only registered nurse on duty and was in charge.

Resident A was taken to hospital on 23 October 2023 following their condition deteriorating further. A local interview was conducted on 26 October 2023 and Mr Osukporu was subsequently dismissed from his role at the Home.

Decision and reasons on application to admit written statement and exhibit of Witness 4

The panel heard an application made by Ms Hazlewood under Rule 31 to allow the written statement of Witness 4 into evidence in relation to Charges 1a) and b). Ms Hazlewood submitted that on review of the case the NMC had decided that the statement and exhibit was uncontentious, and a decision was made not to call Witness 4 before the panel.

In the preparation of this hearing, the NMC had indicated to Mr Osukporu in email correspondence, dated 4 June 2025, that it was the NMC's intention for Witness 4's statement and exhibit to be read. Despite knowledge of the nature of the evidence to be given by Witness 4, Mr Osukporu made the decision not to participate in this hearing and the NMC received no objection from Mr Osukporu. On this basis Ms Hazlewood advanced the argument that there was no lack of fairness to Mr Osukporu in allowing Witness 4's written statement and exhibit into evidence.

Ms Hazlewood submitted that the evidence is highly relevant, and it is not sole and decisive. She submitted that a number of witnesses have also spoken to charges 1a) and 1b), and highlighted the seriousness of the charges alleged would support admitting this evidence.

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

The panel gave the application in regard to Witness 4 serious consideration. The panel noted that Witness 4's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement ... is true to the best of my information, knowledge and belief' and signed by her.

The panel considered whether Mr Osukporu would be disadvantaged by the change in the NMC's position of moving from reliance upon the oral evidence of Witness 4 to that of a written statement and exhibit.

The panel considered that as Mr Osukporu had been provided with a copy of Witness 4's statement and exhibit, as the panel had already determined that Mr Osukporu had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. It also acknowledged the email correspondence from the NMC advising Mr Osukporu of the

evidence to be used throughout hearing and his opportunity to object to the use of the evidence, to which he did not respond. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered the relevance of Witness 4's statement and exhibit and determined that the evidence is not prejudicial and Witness 4 was on the same shift with Mr Osukporu when the allegations arose, therefore considered her evidence relevant. The panel also acknowledged that oral and written evidence provided by other witnesses supported Witness 4's evidence, therefore her statement and exhibit is not the sole and decisive evidence in relation to Charges 1a) and 1b).

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 4 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Hazlewood on behalf of the NMC.

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Home Manager of The Home
- Witness 2: Clinical Lead at The Home.
- Witness 3 Healthcare assistant at The Home.

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

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

Charge 1a) i) and ii)

That you, a registered nurse:

- 1) Between 22 and 23 October 2023 in respect of Resident A
 - a) did not provide care in accordance with Resident A's care plan in that you failed to monitor and/or record adequately, or at all, Resident A's:
 - i) Blood sugar levels
 - ii) Ketone levels

This charge is found proved.

In reaching this decision, the panel took into account, Resident A's care plan, the panel noted that Mr Osukporu had a duty of care to Resident A to manage her unstable diabetic condition as was clearly outlined in the care plan and as he was the only nurse on duty on the shift in question.

The panel took account of the investigatory meeting notes conducted by The Home in addition to email correspondence from Mr Osukporu dated 6 November 2023.

The panel noted that Mr Osukporu stated that he did follow and carry out Resident A's blood sugar level check in accordance with the care plan.

It had regard to Mr Osukporu's email dated 6 November which stated:

*'The allegations of Clinical neglect levelled against me is not true.
I followed the patient A's Care plan accordingly.'*

Mr Osukporu further stated in the email:

*'They said I didn't measure A's blood sugar levels, how then did I know that
A's blood sugar levels was High?'*

The care plan informed the panel of the requirements of a nurse caring for Resident A:

*'...Signs which can be verbalised will be difficult to manage in Resident A's
case and nursing staff need to be vigilant for even minor changes in Resident
A's presentation. If blood sugar reads HI, please ensure you check ketones
using ketones monitor and escalate if abnormal...'*

The panel also had regard to the guidance in the plan regarding ketones and noted the care plan stated:

*'...If blood glucose reads HI please give extra 200mls of water flush via PEF and
document. Check for blood ketones using ketones strips and monitor. If ketones
are MORE THAN 3mmols and blood glucose is HI please call 999...'*

Having knowledge of Resident A's care plan, the panel went on to consider the other evidence before it. It had particular regard was made to the local investigation minutes which stated:

'...[Witness 1] Can you tell us what was handed over to you on commencing your shift 22.10.23?

[Mr Osukporu] I was told that Res A; blood sugar was high.

[Witness 1] What was your plan?

[Mr Osukporu] To give more fluid. I gave 540mls approximately...

... [Witness 1] Have you read Res A care plan?

[Mr Osukporu] Of course.

[Witness 1] It is documented in here that you need to check ketones.

[Mr Osukporu] I didn't do them because I didn't know where the monitor was kept...'

The panel noted that Mr Osukporu was aware that Resident A's blood sugar was high and did not check their Ketone levels as highlighted in the care plan. The panel further acknowledged that the interview was carried out by Witness 1 in the presence of Witness 2 who confirmed via oral evidence that the minutes taken were accurate. The panel found both witnesses to be credible and reliable.

The panel further noted email correspondence from Mr Osukporu dated 6 November 2023, regarding the equipment required to check the ketones which stated:

'The machine needed to do this was kept away beyond my reach, whereas all other apparatus where in A's basket as it has been the tradition!'

Mr Osukporu also stated in the email:

'What I did not do was to measure A's ketones level?'

It determined that Mr Osukporu accepts that he did not measure Resident A's ketone levels.

The panel therefore determined that Mr Osukporu was under a duty to check the blood sugar and ketone levels of Resident A in line with the care plan. In consideration of the documentary and oral witness evidence before it, the panel determined that there was no evidence to show that the checks were completed in compliance with the plan.

The panel therefore finds this charge proved on the balance of probabilities.

Charge 1b)

1) Between 22 and 23 October 2023 in respect of Resident A

b) Failed to escalate Resident A's deteriorating condition

This charge is found proved.

In reaching this decision, the panel took into account Resident A's assessment form, Resident A's night report for 22 October 2023, Resident A's Restore 2 chart, the oral evidence of Witness 2 and the local investigatory meeting notes.

The panel acknowledged that Mr Oskuporu stated that the allegations of clinical neglect were not true, as highlighted within the previous charge. It had further regard to Resident A's assessment form which was completed by Witness 2 following an assessment of Resident A which stated:

'Res A was attended immediately at the start of the shift. Nurse [Mr Osukporu] handed over that Res A was unwell but had not acted and had not opened any monitoring. Blood sugar not checked despite being High, ketones not checked. Seemed unconcerned and Res A NEWS score 12. 999 call and immediate transfer to A&E'

The panel acknowledged that this was further supported in Resident A's Night report form which was completed by Mr Oskuporu and stated:

*'Resident A not looking (well) usual self BM HI at 0600 hrs, T 35.3. BP,
110/81 P 111 ↑ Flushed Sats 64?'*

The panel further acknowledged the presence of a NEWS score and understood the definition of NEWS to be the following:

'National Early Warning Score (NEWS2) promotes a standardised response to the assessment and management of unwell residents...'

The panel noted the seriousness of Resident A having a score of 12 and noted Witness 2's oral evidence in which she stated that it would be the expectation of a registered nurse to immediately escalate the condition in line with the care plan. When asked what she would have done, Witness 2 stated that she would determine a deterioration code using the Restore 2 pathway document to carry out the NEWS score which would determine what plan to follow. The panel had no documentation to show the NEWS score was completed by Mr Oskuporu.

To determine the extent of Resident A's condition, the panel had regard to the care plan which highlighted:

'...Resident A is no longer considered end of life...'

The panel also noted that Witness 2 stated Resident A's overall condition was that she was a very poorly lady with a lot of chronic issues, however she was stable at the time of the incident, she had frequent infections which had been dealt with in the home and caught early on because of the care plans and actions which were in place.

The panel also had regard to the local investigatory meeting minutes in which Mr Oskuporu stated:

'...[Witness 1] When you went to Res A at 6am which we know you did because the carer alerted you and we have confirmed this - you did a set of vital signs, correct?

[Mr Oskuporu] Yes

[Witness 1] Talk me through what happened next.

[Mr Oskuporu] I did no further interventions.

[Witness 1] Did you open a restore2 document and calculate a NEWS score?

[Mr Oskuporu] No because I was doing other stuff

[Witness 1] Did you recognise that the vital signs were abnormal?

[Mr Oskuporu] I just wrote them down and was then spending time putting together my handover and stuff.

[Witness 1] So did you feel like your priority was to prepare your handover even though you had looked at the vital signs?

[Mr Oskuporu] She was being attended to.

[Witness 1] By whom?

[Mr Oskuporu] Well she wasn't attended to all the time, as carers were busy with others also.

[Witness 1] What was the rationale for not documenting the vital signs immediately and following the deterioration policy which is commonplace?

The NEWS score was 13 and no action was taken.*

[Mr Oskuporu] I was going to do it at the end of my shift. I did my best for her.

I am responsible for what I did and didn't do...'

*The panel acknowledged the difference in the NEWS score previously stated as 12, which Witness 2 corrected in oral evidence.

The panel referred to the Restore2 document which states:

‘...[that a] NEWS score of 7 and above requires blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler.’

The panel also had regard to Mr Osukporu’s email correspondence in which he stated:

‘...I’m not an expert in diabetes management and I didn’t know for sure what was different this time...’

The panel therefore acknowledged that there was a gap in knowledge with Mr Osukporu’s knowledge of diabetes management and emergency events. In consideration of the evidence before it, the panel determined that Mr Osukporu had knowledge of Resident A’s care plan which was clear and advised of the appropriate steps to take. The panel determined that he failed to comply with the protocols of the care plan and escalate Resident A’s condition.

The panel therefore finds this charge proved on the balance of probabilities.

Charge 2

- 2) During your internal interview on 26 October 2023, you told Colleague A and Colleague B that you had checked Resident A’s blood sugar levels “at around 10pm prior to giving meds, it was high” or words to that effect, when you had not checked Resident A’s blood sugar levels at that time.

This charge is found proved.

In reaching this decision, the panel took into account the local investigatory meeting notes, oral evidence provided by Witness 1 and 2, Witness 4’s written statement and the oral evidence of Witness 3.

The panel had regard to the investigatory meeting notes, which stated:

[Witness 1] Can you tell us what was handed over to you on commencing your shift 22.10.23?

[Mr Oskuporu] I was told that; blood sugar was high.

[Witness 1] What was your plan?

[Mr Oskuporu] To give more fluid. I gave 540mls approximately.

[Witness 1] What time did you re check the blood sugar?

[Mr Oskuporu] I checked it prior to giving meds at around 10pm. It was high.

[Witness 1] It was not documented When did you re check it again after that?

[Mr Oskuporu] At around 6am.'

Witness 2 confirmed that the meeting notes were a true and accurate record of what was said at the time, this was stated in her oral evidence. Witness 2 further confirmed through her oral evidence that there was no documentary evidence to support that a blood glucose reading was taken around 10pm. The panel noted that this was supported as there was no record on the history of the blood glucose meter that a reading had been taken at or around 10pm.

The panel further had regard to the oral evidence provided by Witness 2 which stated that the glucose meter can only record the blood glucose level of Resident A. The panel determined that this negates an alternative explanation that a different machine can be used to check Resident A's glucose reading.

The panel also acknowledged Witness 4's statement:

'I did not witness/nor am I aware of Mr Oskuporu providing any care to Resident A. I was surprised that I did not see Mr Oskuporu provide any care to Resident A as it had been mentioned during the handover that the resident was not well.'

In consideration of the evidence before it, the panel determined that Mr Osukporu did not check Resident A's blood glucose levels at or around 10pm and on the balance of probabilities, it finds this charge proved.

Charge 3

3) Your actions in charge 2) were dishonest in that you intended Colleague A and Colleague B to believe you had checked Resident A's blood sugar levels at that time when you had not.

This charge is found proved.

In reaching this decision, the panel took into account Resident A's care plan, email correspondence dated 23 Dec 2023. The panel also took into account the advice of the legal assessor who referred to *Ivey v Genting Casinos* [2017] UKSC 67.

The legal assessor also referred to NMC guidance DMA-8 'Making decisions on dishonesty and the professional duty of candour' when making its decision. This states:

'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.'*

The panel acknowledged Mr Osukporu's email correspondence dated 23 December 2023:

'In the first instance, the whole allegation is malicious!'

Having found charge 2 proved, the panel considered the evidence presented to be cogent and reliable and further supported by documentary evidence. The panel further considered Resident A's care plan and the instructions for care and determined that this was clear and concise. The panel determined that a registered nurse would be able to interpret the care plan and act on the instructions given.

The panel also considered that an honest and reasonable professional would acknowledge their failings and would escalate when a Resident was in need of care or has a deteriorating condition. It determined that this was the expectation of a professional in line with the duty of candour and Mr Osukporu had a duty to be transparent and honest with what he had and had not done.

The panel determined that he did not act in accordance with the care plan and sought to mislead his colleagues. It therefore determined that this charge is proved on the balance of probabilities.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Osukporu's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

Ms Hazlewood 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.

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

Ms Hazlewood identified the specific, relevant standards where Mr Osukporu's actions amounted to misconduct. She identified codes; 1.2, 3, 3.1, 10, 10.1, 10.2, 13.1, 13.2, 14, 20, 20.1, 20.2, 23.

Ms Hazlewood submitted that Mr Osukporu was the only nurse on shift and had the responsibility to check the blood glucose and ketone levels of Resident A and provide a level of care in accordance with the care plan in place. She submitted that Mr Osukporu failed to follow the care plan and check Resident A's blood sugar and ketone levels therefore his actions amount to serious misconduct.

Ms Hazlewood further submitted that throughout the local investigation carried out by Witness 2, Mr Osukporu deliberately attempted to cover up his own failings, she reminded the panel of the importance of honest and integrity within the nursing profession and submitted that this also includes honesty in the mistakes made by nurses. Ms Hazlewood submitted that Mr Osukporu's failure to act in accordance

with the care plan whilst then giving a dishonest account of his care, amounts to misconduct.

Submissions on impairment

Ms Hazlewood 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Hazlewood submitted that Mr Osukporu failed to maintain the proper standards of the profession and stated that all four limbs of the *Grant* test have been engaged. She submitted that Mr Osukporu has shown no insight into his failings or engaged with the hearings process. Ms Hazlewood submitted that there is no evidence of Mr Osukporu's current mindset or any attempts to remediate his current failings.

She invited the panel to consider that dishonesty is not easily remediable and highlighted that the code of conduct includes a responsibility of a nursing professional to meet the needs of patients, keep clear and accurate records, make timely records and be open and candid about treatment.

Ms Hazlewood submitted that Mr Osukporu has not shown any remediation or insight into his actions and therefore is likely to repeat his actions in the charges found proved and bring the profession into disrepute. She invited the panel to consider Mr Osukporu's job description and the need to uphold the professional standards of the nursing profession.

She submitted that a finding of impairment should be found on public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*

(No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mr Osukporu's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Osukporu's actions amounted to a breach of the Code. Specifically:

'1. Treat people as individuals and uphold their dignity

To achieve this, you must:

...1.2 make sure you deliver the fundamentals of care effectively...

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

'...3. Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages...

'...6. Always practise in line with the best available evidence

To achieve this, you must:

...6.2 maintain the knowledge and skills you need for safe and effective practice...

'...10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

...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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence...

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

To achieve this, you must:

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

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

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

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly...

...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...

... 23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register...

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 Mr Osukporu failed to meet the standard of what was expected of a registered nurse. The panel found that Resident A was a vulnerable patient who had a clear and concise care plan in place which was not followed by Mr Osukporu.

The panel determined that Mr Osukporu had a duty to escalate Patient A's deteriorating condition in line with the care plan and found that he attempted to deliberately mislead his colleagues through his actions in the charges found proved. The panel found that Mr Osukporu's actions amounted to dishonesty which is deplorable to the profession.

The panel found that Mr Osukporu'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, Mr Osukporu's fitness to practise is currently impaired.

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

'The question that will help decide whether a professional's fitness to practise is impaired is:

"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

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

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

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

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

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

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

- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that Resident A was put at risk of physical harm as a result of Mr Osukporu's misconduct. Mr Osukporu'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.

Regarding insight, the panel considered Mr Osukporu's email correspondence with the NMC and determined that he has not shown any insight into his failings. Mr Osukporu had not engaged with the NMC since 10 June 2024 and referred to the allegations as malicious in his correspondence with the NMC. The panel found that there is no evidence before it to show that Mr Osukporu has demonstrated any insight into how his actions put Resident A at risk of harm, or why what he has done was wrong and how this impacted negatively on the reputation of the nursing profession.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Osukporu has taken steps to strengthen his practice. The panel took into account a certificate provided by Mr Osukporu dated 10 June 2024 in which he carried out an online training course called 'understanding diabetes'. The panel further noted that there has since been no reflection provided or engagement with the NMC to show whether he has embedded this training in his practice and strengthened the gap in his knowledge regarding diabetes care.

The panel is of the view that there is a risk of repetition based on the lack of engagement, training, remorse and insight shown by Mr Osukporu. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because of the seriousness of the charges found proved which amounted to dishonesty. The panel were of the view that a member of the public would not feel confident having Mr Osukporu continue with unrestricted practice.

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

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mr Osukporu's registration has been suspended.

Submissions on sanction

Ms Hazlewood informed the panel that in the Notice of Hearing, dated 25 July 2025, the NMC had advised Mr Osukporu that it would seek the imposition of a suspension order of 12 months with review if it found Mr Osukporu's fitness to practise currently

impaired. During the course of the hearing, the NMC revised its proposal and submits that in light of the facts in this case, the panel may consider a strike off order to be appropriate.

Ms Hazlewood invited the panel to consider Mr Osukporu's lack of insight into his failings including his statement that the concerns raised were malicious as an aggravating factor. She further highlighted that Mr Osukporu had not shown any remorse or remediation, and his conduct put people receiving care at risk of suffering harm. She also invited the panel to consider these as mitigating factors.

Ms Hazlewood further made note that Mr Osukporu had previously been subject to a conditions of practice order for 18 months which was allowed to lapse on 23 May 2022. She submitted that the facts of the previous case were dissimilar in nature however invited the panel to consider the previous sanction in place when making their decision.

Ms Hazlewood submitted that due to the nature and seriousness of the facts found proved, taking no action and a caution order would not be sufficient to protect the public. She stated that a suspension order would be appropriate in consideration of the dishonesty found and Mr Osukporu's failure to address the clinical and attitudinal concerns raised in his failings.

Decision and reasons on sanction

Having found Mr Osukporu's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Lack of insight into failings
- Conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- Certificate of training dated 10 June 2024 ‘Understanding Diabetes ‘

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Osukporu’s practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *‘the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.’*

The panel considered that Mr Osukporu’s misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *Identifiable areas of the nurse or midwife’s practice in need of assessment and/or retraining.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can easily be addressed through

retraining due to the dishonesty found within the proven charges. The panel also noted that Mr Osukporu has been subject to a conditions of practice order and he has been unable to implement the previous conditions imposed. The panel further noted that Mr Osukporu has not engaged in the hearings process further supporting its decision that a conditions of practice order would not be appropriate or proportionate in the circumstances of this case.

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

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

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

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel acknowledged the seriousness of the case and that Resident A was a vulnerable patient which Mr Osukporu had failed to adequately care for by failing to follow the care plan in place and escalating their deteriorating condition.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and that this was a single incident, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Osukporu's case to impose a striking-off order.

The panel also had regard to the NMC guidance SAN-1:

'Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious...'

It noted that Mr Osukporu's actions had seriously fallen short of the expectations of a professional nurse and there was a breach in the duty of candour by failing to adequately care for a vulnerable patient. The panel acknowledged that this was a single incident and considered Mr Osukporu's dishonesty to be less serious in this regard, therefore found that a striking off order would not be appropriate.

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

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct and provide Mr Osukporu sufficient time to address his failings and strengthen his practice.

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

Any future panel reviewing this case would be assisted by:

- Mr Osukporu's full engagement with the NMC and future reviewing panel;
- Evidence of insight and reflections from Mr Osukporu demonstrating insight and appreciation of the seriousness of his misconduct;
- Evidence of steps taken to remediate the gaps in Mr Osukporu's knowledge, this includes training courses.

Submissions on interim order

The panel took account of the submissions made by Ms Hazlewood. She submitted that it was necessary and proportionate to impose an interim suspension order for a period of 18 months to cover the statutory appeal period of 28 days in which an appeal can be made. She stated that this was necessary to adequately protect the public and in the public interest.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the statutory appeal period of 28 days in which an appeal can be made.

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

This will be confirmed to Mr Osukporu in writing.

That concludes this determination.