Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Friday, 5 September 2025
Monday, 8 September 2025 - Tuesday, 9 September 2025

Virtual Meeting

Name of Registrant:	**Namwinga Leah Nalwamba**
NMC PIN:	20B0175O
Part(s) of the register:	Nursing - Sub part 1 RN1: Adult nurse, level 1 (6 February 2020)
Relevant Location:	Cheshire
Type of case:	Misconduct
Panel members:	Angela Kell (Chair, Lay member) Roisin Toner (Registrant member) Anita Kaur Mobberley (Lay member)
Legal Assessor:	Juliet Gibbon (5 and 8 September 2025) Valerie Paterson (9 September 2025)
Hearings Coordinator:	Bethany Seed (5 September 2025) Eleanor Wills (8 and 9 September 2025)
Facts proved:	Charges 1a, 1b, 2a, 2b, 2c, 3, 4a, 4b, 4c, 5a, 5c, 5d, 5e, 5f
Facts not proved:	Charge 5b
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Miss Nalwamba's registered email address by secure email on 29 July 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the charges, the date after which the case may be considered, the reasons for a meeting rather than a hearing, the evidence being relied upon, and the fact that this meeting was to be heard virtually.

In light of all of the information available, the panel was satisfied that Miss Nalwamba has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charges

That you, a registered nurse:

1. On 11 April 2020 moved Resident B from the floor:
    a. Before completing a set of observations.
    b. By picking him up under his arms.

2. On the night shifts of 26/27 December 2020 and/or 31 December/1 January 2021:
    a. Failed to review and/or change Resident A's dressing.
    b. Did not record any observations in the iCare system and/or in the progress notes of the residents.
    c. Failed to check the diary for any tasks.

3. On the night shift of 31 December 2020/1 January 2021 said to Colleague 1 words to the effect of "*no, you don't work as a carer*" when Colleague 1 suggested that she would help the carers due to staff shortages.

4. Slept on duty:

    a. On an unknown date in November 2020.
    b. On the night shift of 30/31 December 2020.
    c. On the night shift of 31 December 2020/1 January 2021.

5. On the night shift of 8/9 January 2021:
    a. Were watching a film on your computer.
    b. Failed to check the diary for any tasks.
    c. Failed to reposition one or more residents as required.
    d. When completing one or more care plan reviews did not spend sufficient time considering each of them.
    e. Did not take any action on the iCare system between 23:53 and 06:10.
    f. Did not review one or more of the overdue actions on the iCare system.

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

Background

On 5 February 2021, the Nursing and Midwifery Council (NMC) received a referral from the Head of Operations at Morris Care Limited (the Organisation). The referral contained allegations that arose whilst Miss Nalwamba was employed as a Registered Nurse at Corbrook Park Nursing Home (the Home).

Miss Nalwamba commenced her employment at the Organisation on 14 October 2019 whilst she completed her OSCE training. She gained her NMC PIN on 6 February 2020, and on 2 March 2020 she was transferred to work at the Home. The Home's residents include elderly, frail adults living with dementia and adults with complex learning difficulties.

In January 2021, concerns were raised about Miss Nalwamba's conduct at work. The concerns included sleeping and watching films whilst on duty, failure to complete tasks she was responsible for, including wound management and record keeping. It was also alleged that Miss Nalwamba failed to follow correct protocol after Resident B had a fall.

Miss Nalwamba was suspended from the Home on 22 January 2021 and was dismissed from the Home on 26 January 2021 under stage 4 of the disciplinary process. She had been on a final conduct warning for 12 months.

Miss Nalwamba made some admissions to the above concerns during the internal investigations at the Home, but she has not provided any formal response to the NMC in relation to the allegations.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Registered Home Manager of the Home during the alleged incidents.

- Witness 2: Nurse Team Leader at the Home during the alleged incidents.

- Witness 3: Registered Nurse at the Home during the alleged incidents.

- Witness 4: Care Supervisor at the Home during the alleged incidents.

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

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

Charge 1a

"That you, a registered nurse:

1. On 11 April 2020 moved Resident B from the floor:

    a. Before completing a set of observations."

This charge is found proved.

In reaching this decision, the panel took into account the wording of the charge and it determined that "*observations*" would relate to the clinical observations that should be taken before moving a patient, who had experienced an unwitnessed fall and was complaining about head, neck and back pain. For example, Resident B's temperature, blood pressure and pulse readings as well as neurological observations.

The panel took into account Miss Nalwamba's Investigation Meeting notes dated 11 April 2020, her Employment Review Meeting notes dated 16 April 2020, Witness 1's statement to the NMC and the Home's local investigation statements from Person A and Person B.

In particular, the panel had regard to the Investigation Meeting notes, where Miss Nalwamba was asked why she did not take Resident B's observations when he was on the floor, to which she stated:

“I wanted to give [Resident B] his pain meds. I went downstairs to get the other nurse but she was busy in the lounge I continued with my medication round.”

The panel considered this to be Miss Nalwamba admitting that she had not completed the observations on Resident B immediately after having found him on the floor after a fall.

The panel had regard to the written statement of Person B, dated 11 April 2020 which stated:

“I immediately went to check on [Resident B]. He does not appear to have any injuries. I then went to find LN to ask if she had completed a set of observations yet for [Resident B], she said no and that she was getting him his medications first.”

The panel noted that Miss Nalwamba gave a conflicting account in her Employment Review Meeting on 16 April 2020. These notes stated:

“LN said that she first checked that he was alright. Checked his vital signs. She then asked him if he was able to weight bear.”

The panel noted that Miss Nalwamba’s account of this incident was inconsistent with what she had previously stated during the internal investigation. It considered that the written statements of Person A and Person B are hearsay evidence as they have not provided statements to the NMC. However, both accounts are consistent, corroborative and also support Miss Nalwamba’s contemporaneous account that she did not conduct a set of observations on Resident B as she prioritised getting his medication.

The panel therefore determined that this charge is found proved.

Charge 1b

"That you, a registered nurse:

1. On 11 April 2020 moved Resident B from the floor:

    b. By picking him up under his arms."

This charge is found proved.

In reaching this decision, the panel took into account Person A's local written statement, the Investigation notes of Person A dated 11 April 2020, Miss Nalwamba's Investigation Meeting notes dated 11 April 2020 and Witness 1's witness statement.

The panel noted that Person A's statement dated 11 April 2020, gives a direct, contemporaneous account of the incident, detailing how Miss Nalwamba picked Resident B up by lifting him under his arms, which stated.

> *"I was collecting the jugs when I found [Resident B] on the floor. I pressed the emergency buzzer. When the nurse came, she tried to pick him up, putting her hand under his right arm. As [Resident B] started shouting that he was in pain, the nurse asked him where he was in pain and he said that his head was hurting as well as his neck and back. After rubbing [Resident B]'s head, the nurse put both of her hands under [Resident B]'s arms and picked him up."*

This account is further supported in the Investigation Meeting notes, where Person A demonstrated the technique used by Miss Nalwamba to lift Resident B:

> *"[Resident B] was on his right side ([Person A] rolls onto right side), and LN put an arm under [Resident B]'s right arm and started to pull him up. [Resident B] shouted that it hurt and he was in pain."*

In Miss Nalwamba's Investigation Meeting notes, she stated in relation to Resident B that:

“he was struggling. He couldn’t stand. I put him on the bed.”

In Witness 1’s witness statement, she stated that:

“Miss Nalwamba admitted that the way in which she moved a resident on 11 April 2020 was against the Home’s Moving and Handling Policy.”

The panel noted that Person A’s account is direct, contemporaneous evidence which was not contradicted by Miss Nalwamba’s contemporaneous account in the Home’s local investigation. The panel did note that Person A’s written statement is hearsay evidence as they have not provided a statement to the NMC for these proceedings. However, the panel noted that the written statement was produced for the purpose of the local investigation, it is signed and dated by Person A and that there is no reason to suggest that Person A’s account has been fabricated.

In light of the above, the panel determined that charge 1b is found proved.

Charge 2a

“That you, a registered nurse:

2. On the night shifts of 26/27 December 2020 and/or 31 December/1 January 2021:

    b. Failed to review and/or change Resident A’s dressing.”

This charge is found proved.

In reaching this decision, the panel took into account Miss Nalwamba’s job description from the Home, the Home’s Wound Management Policy, the Staff Allocation Rota for 26 December 2020 /1 January 2021, Witness 1’s witness statement, Miss Nalwamba’s Investigation Meeting notes, Disciplinary Meeting notes and Witness 2’s witness statement.

The panel first considered the job description provided by the Organisation which stated the purpose of the Night Nurse role as:

> *"To be responsible for the provision of nursing care for all residents…"*

The panel also considered the Wound Management Policy, which stated:

> *"A major influence on wound healing is accurate and continued assessment by the nursing staff of response to treatment and recognising when to seek advice from specialists."*

The panel was therefore satisfied that it was the role of a nurse at the Home to review and change dressings when necessary.

The panel next considered the Staff Allocation Rota for the dates of this charge, and it noted that Miss Nalwamba was the on-duty Night Nurse on both the 26/27 December 2020 and 31 December 2020/1 January 2021. The panel further considered Witness 1's witness statement which stated:

> *"When Miss Nalwamba was on duty, she was the nurse in charge of the shift and was responsible for supporting and supervising all staff on shift in addition to providing adequate care to the residents in line with the Home's policies and procedures. Moreover, Miss Nalwamba was responsible for completing observations, administering medications, reviewing care plans in addition to numerous other responsibilities."*

The panel was therefore satisfied that it was Miss Nalwamba's responsibility to review and change dressings when necessary.

The panel next considered whether Miss Nalwamba failed to review and/or change Resident A's dressing on these listed dates.

The panel had regard to the Investigation Meeting notes dated 9 January 2021. It noted that in this interview, Miss Nalwamba confirmed that in respect of the wound review chart:

“I didn’t check. I don’t know if there were any wounds I didn’t check.”

The panel also considered the Wound Chart for Resident A dated 22 January 2021, and it noted that there are no updates on the chart on these dates when Miss Nalwamba was on duty.

The panel took into account Witness 2’s witness statement which stated:

“On 26 December 2020, Miss Nalwamba was responsible for changing Resident A's dressing. Resident A had a recurrent stage 2 pressure ulcer on his buttock which needed to be changed on 26 December 2020. Miss Nalwamba was on shift and failed to change this dressing.”

Witness 2 further stated:

“I changed Resident A's dressing on 29 December 2020. In accordance with Tissue Viability Nursing ("TVN") guidance, I put the date [29 December 2020] on Resident A's dressing and signed it. This also allows me to identify when I come to change dressings, whether I have previously dressed the wound or if the wound had been changed. Resident A's dressing was due to be changed on the night shift of 1 January 2021. Miss Nalwamba was again on shift and failed to change Resident A's dressing.

Miss Nalwamba would have been aware that it was her responsibility to change Resident A's dressing on both 26 December 2020 and 1 January 2021. Miss Nalwamba would have known this as it was detailed in the care records under Resident A's wound chart. The due date for Resident A's change of dressing would also have been in diary. Despite this, Miss Nalwamba failed to deliver the clinical intervention required.”

The panel noted that in the notes of the disciplinary meeting held on 26 January 2021, Miss Nalwamba admitted that she had not checked the diary on 26 December 2020. It is recorded in the notes that Miss Nalwamba stated that she had checked the diary on 31

December 2020. This, however, conflicted with what she had previously told Witness1 during the investigation meeting on 9 January 2021.

"[Witness 1]: Was there anything in the diary?

LN: I didn't check the diary".

and

"[Witness 1]: Was there anything for you to do?

LN: I didn't check. I don't know if there were any wounds I didn't check".

The panel was satisfied on the basis of the contemporaneous evidence that Miss Nalwamba did not adequately review and/or change Resident A's dressing on the dates listed in the charge. In light of the above, the panel determined that charge 2a is found proved.

Charge 2b

"That you, a registered nurse:

2. On the night shifts of 26/27 December 2020 and/or 31 December/1 January 2021:

    b. Did not record any observations in the iCare system and/or in the progress notes of the residents."

This charge is found proved.

In reaching this decision, the panel took into account the Meeting notes from Miss Nalwamba's Disciplinary Meeting held on 26 January 2021 and Witness 1's witness statement.

In particular, the panel noted that this allegation was put to Miss Nalwamba in the Disciplinary Meeting and that she confirmed that she had received training on the iCare system, but that she had been unable to input some of the observations because the device for inputting information was kept with the carers. When Miss Nalwamba was asked why she could not have used the laptop provided to her to input this information, she confirmed that this was a possible alternative. The panel noted that during this meeting, Miss Nalwamba had been unable to provide evidence that she conducted any nightly observations on these dates and could not provide a reason for this.

Whilst the panel noted that the burden rests on the NMC to prove that it is more likely than not that the facts alleged in the charge occurred, it took into account that Miss Nalwamba did not deny this allegation when it was put to her in the local investigation. The panel also noted that Witness 1 carried out an audit of the iCare system and that she was unable to find any record of observations being carried out. The panel acknowledged that not all the care plan notes for each resident on these dates are before it, but the panel considered Witness 1's evidence to be credible and consistent and it was satisfied that it was more likely than not that Miss Nalwamba did not record observations on the iCare system on these dates. Therefore, the panel determined that charge 2b is found proved.

Charge 2c

"That you, a registered nurse:

2. On the night shifts of 26/27 December 2020 and/or 31 December/1 January 2021:

    c. Failed to check the diary for any tasks."

This charge is found proved.

In reaching this decision, the panel took into account Miss Nalwamba's Disciplinary Meeting notes and Witness 2's witness statement.

For the same reasons as set out in charge 2a, the panel concluded that Miss Nalwamba had a duty to check the diary for any tasks.

The panel had regard to the Disciplinary Meeting notes, in particular that Miss Nalwamba described the handover process which included reference to writing on a sheet of paper the tasks that had been performed during her shift, and that the diary of further tasks would be updated. The panel noted that Miss Nalwamba admitted that she *"did not check the diary on 26 December, because she was ill."*

In the notes of the Investigation Meeting, dated 9 January 2021, Witness 1 recorded that Miss Nalwamba admitted that she did not check the dairy on 31 December 2020 because she *"never thought they put anything in the diary. Nothing was handed over."*

The panel considered that this was consistent, contemporaneous evidence that Miss Nalwamba did not check the diary on the dates specified within this charge.

In addition, the panel noted that Witness 2 in their witness statement stated that:

> *"For example, Miss Nalwamba would not open the diary during the night shift to ascertain whether there were any tasks which she should or could have completed."*

The panel acknowledged that this statement does not specify a particular date and so cannot be attributed to this charge. However, it considered that this was further evidence that Miss Nalwamba did not consistently check the diary and determined that this supported the charge. The panel concluded that it was more likely than not that Miss Nalwamba failed to check the diary on 26/27 December 2020 and 31 December 2020/1 January 2021.

In light of the above, the panel determined that charge 2c is found proved.

Charge 3

"That you, a registered nurse:

3. On the night shift of 31 December 2020/1 January 2021 said to Colleague 1 words to the effect of "*no, you don't work as a carer*" when Colleague 1 suggested that she would help the carers due to staff shortages."

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement. It noted that Witness 3 is the same person as Colleague 1 as contained in the charge. In particular, the panel noted that Witness 3 stated:

> *"We were short-staffed on this shift. Therefore, I told the care team and Miss Nalwamba that I would complete the medication round on the ground floor and lower ground floor and that once this had been completed, I would come up to assist them. In response to this, Miss Nalwamba said "no, you don't work as a carer." I told Miss Nalwamba that the care team required assistance and that it was part of our training to complete such duties as you cannot be a good nurse if you are not a good carer."*

The panel considered that this witness statement is signed and dated and was produced for the purpose of these proceedings. The panel considered Witness 3 to be a credible and consistent witness and found that there is no suggestion that there is any reason for this statement to be fabricated. Therefore, the panel determined that, it is more likely than not, this comment was made by Miss Nalwamba to Witness 3. Accordingly, it concluded that charge 3 is found proved.

Charge 4a

"That you, a registered nurse:

4. Slept on duty:

    d. On an unknown date in November 2020."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement. In particular, the panel noted that Witness 2 stated:

> *"I was on a night shift with Miss Nalwamba in November 2020, I went to check on her and I also required her signature for a controlled drug administration / documentation. I found Miss Nalwamba sleeping on a two-seater sofa, covered in a blanket. I said "Hi Leah" but received no response. Therefore, it was necessary for me to raise my voice in order to wake Miss Nalwamba."*

The panel further noted that Witness 2 stated:

> *"At the end of the conversation, I warned Miss Nalwamba that under no circumstance was she to sleep whilst on duty. Miss Nalwamba would have been very well aware of the Organisation's policy in regards to sleeping in November 2020. There is no tolerance for such activity. There is no doubt that after my conversation with Miss Nalwamba, it was abundantly clear to her that she was not allowed to sleep whilst on shift."*

The panel considered that Witness 2 was credible and consistent in their evidence, and it had no reason to believe that the allegations against Miss Nalwamba had been fabricated. Therefore, the panel determined that charge 4a is found proved on the balance of probabilities.

Charge 4b

"That you, a registered nurse:

4. Slept on duty:

b. On the night shift of 30/31 December 2020."

This charge is found proved.

In reaching this decision, the panel took into account the further Investigatory Meeting notes with Witness 3, dated 20 January 2021 and Witness 3's witness statement.

In particular, the panel noted that in the meeting notes, Witness 1 asked Witness 3 if they had seen Miss Nalwamba asleep on duty previously and Witness 3 stated:

> *"[Witness 3] said 30th December in Cedar, she was fast asleep at 11 o'clock when I went there to get a signature, I had to wake her up."*

This account is supported by Witness 3 in their witness statement, where they stated:

> *"During this shift, I required Miss Nalwamba to second-check and counter-sign documentation for administration of a controlled drug for a resident. Therefore, I went across to Cedar Courts to get her signature. At around 23:00, when I approached Miss Nalwamba, she was lying on the sofa in the upstairs lounge. I could tell that she was fast asleep even from afar. It was necessary for me to wake Miss Nalwamba up in order to get her signature. I had difficulty waking Miss Nalwamba as she was fast asleep."*

The panel considered that Witness 3 had been consistent in their evidence.

The panel noted that in the internal Investigation Meeting on 9 January 2021, when asked if she slept on waking night duty Miss Nalwamba responded *"yes, maybe for five minutes*

of so." She denied being previously spoken to about sleeping on duty and further stated *"almost everyone sleeps on their breaks."* The panel was satisfied that Miss Nalwamba had admitted to sleeping on duty during the shift and therefore it determined that charge 4b is found proved on the balance of probabilities.

Charge 4c

"That you, a registered nurse:

4. Slept on duty:

    c. On the night shift of 31 December 2020/1 January 2021."

This charge is found proved.

In reaching this decision, the panel took into account email correspondence from Witness 2 to Witness 1 and the witness statements of Witness 3 and Witness 4.

In particular, the panel noted the contemporaneous email dated 7 January 2021 from Witness 2 to Witness 1 that includes an excerpt from an email from Witness 4 which stated:

> *"I have to bring to you attention a situation that occurred on New Year's Eve where even though we were one team member short on the case side one of the nurses was sleeping for many hours and did not care enough to offer any help through the situation. I understand* [PRIVATE] *offering a bit of help while two nurses were on duty would have been appropriate."*

In addition, the panel had regard to Witness 4's statement, in which they confirmed:

> *"I can confirm that I witnessed Miss Nalwamba asleep during this night shift. Miss Nalwamba was reclined in the middle floor lounge. Miss Nalwamba was lying in an armchair and had lowered the lights. I believe that I passed Miss Nalwamba around*

five or six times over a number of hours and she was asleep and had not moved. Miss Nalwamba was not watching anything on the television nor talking on the phone; she was clearly asleep."

The panel also considered the Investigation Meeting notes dated 20 January 2021, with Witness 3, in which they stated in response to seeing Miss Nalwamba asleep on 31 December 2020:

"[Witness 3] said at 11pm, 1am, 3am and 5am; LN was asleep on each occasion. [Witness 1] asked wow[sic] many times did [Witness 3] see her asleep throughout the shift? [Witness 3] said Four times at least. LN was in the 1st floor lounge, with her legs up and cushions under her head."

The panel noted that in her Disciplinary Meeting on 26 January 2021, Miss Nalwamba denied this allegation and stated:

"LN claimed that on the shift of 31 December she had moved to a lying position to ease her backache. She had elevated her legs for approximately 30 mins to reduce swelling caused by long periods of time in a sitting position [PRIVATE]. *This issue had been escalated to LN's team leader but LN could not remember when this was. During this period LN could not remember what she was doing* [PRIVATE]. *Following this 30-minute period in this position, LN resumed her nightly observations starting with the resident adjacent to the lounge area. She did not communicate with any other members of staff during these observations."*

However, the panel considered that there are several contemporaneous and consistent accounts that suggest that on 31 December 2020/1 January 2021, Miss Nalwamba was asleep on shift for approximately six hours. The panel noted that it had no reason to believe that this allegation was fabricated, and the evidence appears to corroborate the pattern of behaviour that has been alleged. The panel further considered that Miss Nalwamba had admitted to sleeping on duty during the local Investigation Meeting on 9 January 2021. In light of the above, the panel determined that charge 4c is found proved on the balance of probabilities.

Charge 5a

"That you, a registered nurse:

5. On the night shift of 8/9 January 2021:

a. Were watching a film on your computer."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, the photograph taken by Witness 1 on 9 January 2021 and the Investigation Meeting notes dated 9 January 2021.

The photograph taken by Witness 1 shows a video being played on Miss Nalwamba's laptop with the writing *"Hollywood Movies"* at the top of the screen. This is further supported by the statement of Witness 1 which stated:

> *"On the morning of 9 January 2021, I attended the Home for an unannounced night inspection. I arrived at 04:20. Miss Nalwamba was on shift. I found Miss Nalwamba sitting in her coat and watching a film on her laptop in the ground floor nurse's station at 04:32. I obtained Miss Nalwamba's consent and took a photograph of how I had found Miss Nalwamba. Miss Nalwamba confirmed that she had been watching a film."*

This account is further supported by the Investigation Meeting notes, in which Witness 1 confirmed that they had received reports about Miss Nalwamba watching films whilst on duty. During the meeting, Miss Nalwamba accepted this and stated that she did so to avoid falling asleep.

In light of the above, the panel determined that charge 5a is found proved on the balance of probabilities.

Charge 5b

"That you, a registered nurse:

5. On the night shift of 8/9 January 2021:

b. Failed to check the diary for any tasks."

This charge is found not proved.

In reaching this decision, the panel took into account Witness 1's witness statement and Miss Nalwamba's Disciplinary Meeting notes. In the meeting, Miss Nalwamba appears to have admitted to not checking the diary on 26 December 2020, but the allegation regarding the 8/9 January 2021 was not put to her. Therefore, there is no response from her to this allegation.

Witness 1 in their statement stated:

> *"Miss Nalwamba clearly failed to check the diary or review relevant care plans on the shift of 8-9 January 2021. The only recorded activity that night on iCare was from 23:11 to 23:53 where Miss Nalwamba allegedly completed care plan reviews."*

The panel noted that Witness 1 did not provide an explanation or basis for her conclusion that Miss Nalwamba had failed to check the diary or review the relevant care plans on the shift of 8-9 January 2021.

The panel considered that although elsewhere, Miss Nalwamba has admitted to not checking the diary, it could find no cogent evidence that she did not check the diary on 8/9 January 2021. In the absence of any further evidence, the panel determined that the NMC has not discharged its burden of proof for this charge. Accordingly, the panel found charge 5b not proved.

Charge 5c

"That you, a registered nurse:

5. On the night shift of 8/9 January 2021:

c. Failed to reposition one or more residents as required."

This charge is found proved.

In reaching this decision, the panel took into account the repositioning charts of five residents, dated 8/9 January 2021, the Organisation's Wound Management Policy and the witness statement of Witness 1.

The panel noted that during the local investigation into Miss Nalwamba's conduct, Witness 1 had conducted an audit of the actions taken on the iCare system by Miss Nalwamba. It further noted Witness 1's statement that:

> *"I can confirm that from 23:53 on 8 January 2021 until 06:10 on 9 January 2021, no action was taken by Miss Nalwamba on the iCare system. In addition to this, the Home's repositioning chart for 5 residents on 8 January 2021 – 9 January 2021, evidence that appropriate care was not provided to them by Miss Nalwamba. All of these five residents should have been repositioned by Miss Nalwamba during this night shift, but were not."*

The panel acknowledged that there are no residents' care plans before it outlining how often and/or when the residents needed to be turned. However, it took into account the repositioning charts in which residents went between 7 -13 hours without repositioning when Miss Nalwamba was the nurse in charge on 8/9 January 2021. The panel considered one example in the repositioning charts of Resident E, who went from 18:35 on 8 January 2021 to 08:16 the next morning without being repositioned and therefore had not been repositioned all night. The panel noted that in Resident E's previous notes, they were being repositioned every four or five hours. The panel made a reasonable inference

from this information that residents with repositioning charts should have been turned more frequently than records show.

In light of the above, the panel determined that charge 5c is found proved on the balance of probabilities.

Charge 5d

"That you, a registered nurse:

5. On the night shift of 8/9 January 2021:

    d. When completing one or more care plan reviews did not spend sufficient time considering each of them."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement and Miss Nalwamba's Disciplinary Meeting notes.

In particular, Witness 1 in their statement confirmed:

> *"The only recorded activity that night on iCare was from 23:11 to 23:53 where Miss Nalwamba allegedly completed care plan reviews. As aforementioned, Miss Nalwamba had stated that during this 42 minute period, she had signed 8 care plans to state that she had reviewed them. However, none of those 8 care pans had in fact been satisfactorily reviewed. The time Miss Nalwamba spent on each care plan ranged from 2 minutes to 13 minutes. This is insufficient time to conduct any sort of reasonable or meaningful clinical review of a person-centred care plan or the assessed needs of the resident. I would have expected a full care plan review for one resident to take around 3 hours."*

When this allegation was put to Miss Nalwamba in her Disciplinary Meeting, she confirmed:

"LN acknowledged that there were gaps in the information that she had recorded. LN admitted that she needed to make more detailed notes and that she did not ask other members of care staff for information or make any investigations."

The panel noted that the electronic record provided clear timings showing access by staff to each resident's records. The panel considered that Witness 1 conducted an audit showing Miss Nalwamba's access to the system and the time she spent reviewing resident's records.

In light of the above, the panel determined that charge 5d is proved on the balance of probabilities.

Charge 5e

"That you, a registered nurse:

5. On the night shift of 8/9 January 2021:

e. Did not take any action on the iCare system between 23:53 and 06:10."

This charge is found proved.

In reaching this decision, the panel took into account the iCare digital record audit and the witness statement of Witness 1. The panel acknowledged that it did not have before it the full records of the iCare system for each resident at the Home between these times. However, it took into account the evidence of Witness 1 which stated:

"I can confirm that from 23:53 on 8 January 2021 until 06:10 on 9 January 2021, no action was taken by Miss Nalwamba on the iCare system."

The panel considered that Witness 1 had been credible and consistent in their evidence, and that they had completed a full audit of the records, which would have clearly demonstrated the time at which the system was accessed. Therefore, the panel was satisfied that charge 5e is found proved on the balance of probabilities.

Charge 5f

"That you, a registered nurse:

5. On the night shift of 8/9 January 2021:

f. Did not review one or more of the overdue actions on the iCare system."

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, the notes of Miss Nalwamba's Disciplinary Meeting and the Investigation Meeting notes dated 9 January 2025.

In their statement Witness 1 stated:

> *"I asked Miss Nalwamba why on the current shift (night shift of 8-9 January 2021), she was watching a film and her explanation was that she had completed all of her duties which were expected oh[sic] her and had reviewed 8 care plans. However, Miss Nalwamba was not honest with me as when I reviewed the iCare system, I found that there were 139 missed actions including missed wound care reviews and fluid intake alerts."*

Witness 1 further clarified that:

> *"I would have expected Miss Nalwamba to have made her way through the missed and overdue actions on the iCare system throughout the shift in order of priority. Miss Nalwamba did not do this. The Home is a 24-hour service, and it was Miss Nalwamba's responsibility to complete as many of the missed or overdue actions as possible."*

When this allegation was put to Miss Nalwamba in the Investigation Meeting on 9 January 2021, she confirmed that she had not reviewed the 139 overdue actions because *"it was on the day shift."* In her disciplinary meeting, Miss Nalwamba stated that 120 of the missed

actions related to Cedar Court which were not relevant to the unit on which she was working.

The panel had regard to the wording of the charge, which requires it to find whether Miss Nalwamba did not review one or more of the overdue actions on the iCare system. The panel was satisfied that even if Miss Nalwamba's assertion that the majority of tasks related to the other unit, she would still have been responsible for the remaining 19 overdue actions for Corbrook. The panel therefore concluded that charge 5f is found 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 Miss Nalwamba'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. Firstly, 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 Nalwamba's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'

The NMC 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.

The NMC identified the specific, relevant standards where Miss Nalwamba's actions amounted to misconduct. The NMC submitted that the breaches of the Code that amount to misconduct are serious. Miss Nalwamba failed to safeguard residents in her care by sleeping on duty and watching films, undertake wound management reviews, complete care reviews to a satisfactory standard and tend to a resident's pressure ulcer. The NMC submitted that these are fundamental nursing skills that can have significant implications with respect to patient safety if not carried out adequately. The failings involved a serious departure from the standards expected of a registered professional and amount to serious professional misconduct.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin)

The NMC invited the panel to find Miss Nalwamba's fitness to practise impaired. The NMC submitted that the first three limbs of the *Grant* test are satisfied.

The NMC submitted that Miss Nalwamba placed Resident A at risk of unwarranted harm by failing to review and/or change his dressing so placing him at greater risk of infection. Miss Nalwamba could have seriously injured Resident B by moving him from the floor without completing a set of observations and not following the appropriate manual handling techniques. Furthermore, Miss Nalwamba placed residents at risk of harm by

failing to complete care reviews to a satisfactory standard and sleeping and watching films whilst on duty. The NMC submitted that this is a case which directly relates to patient care. Miss Nalwamba actions and inactions compromised patient safety and had the potential to cause serious harm to the residents in her care. The NMC submitted that Miss Nalwamba's conduct has put residents at unwarranted risk of harm and due to her lack of insight and remediation, there is a risk of the conduct being repeated. At the time of the incidents in November 2020, December 2020 and January 2021 Miss Nalwamba was already subject to a final conduct warning which she had received as a result of incidents in April 2020.

The NMC submitted that the concerns about Miss Nalwamba's actions are serious as this is a serious departure from the standards expected of a registered health professional. Registered health professionals occupy a position of privilege and trust in society and are expected at all times to meet adequate standards of providing patient care. Residents and families must be able to trust registered health professionals with their lives and the lives of their loved ones. The NMC submitted that Miss Nalwamba's misconduct has brought the profession into disrepute and breached fundamental tenets of the nursing profession.

The NMC submitted that Miss Nalwamba's failings are directly linked to her clinical practice, and some could be classed as attitudinal. The NMC submitted that some of the concerns namely, charges 1 and 2 are remediable in that they relate to discrete and easily identifiable areas of clinical practice. However, the failings regarding attitudinal concerns specifically at charges 3, 4 and 5 can be more difficult to address than those relating to clinical matters.

The NMC submitted that Miss Nalwamba has displayed limited insight and therefore there is a continuing risk to the public and a finding of impairment is necessary in order to protect the public.

Furthermore, the NMC submitted that the seriousness of the allegations regarding a failure to safeguard residents by sleeping on duty, neglecting residents' care by failing to undertake wound management review and failing to complete care reviews to a satisfactory standard requires a finding of impairment to be made to uphold proper professional standards and conduct and to maintain public confidence in the profession.

The concerns have not been fully remediated, and the NMC submitted that Miss Nalwamba has not shown the requisite amount of insight to mitigate the public interest concerns previously identified.

The panel accepted the advice of the legal assessor which included reference to NMC Guidance and a number of relevant judgments. These included *Roylance v GMC (No. 2)* [2000] 1 AC 311, *R (on the Application of Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin), *Calhaem v GMC* [2007] EWHC 2606 (Admin), in respect of misconduct; and *Meadow v GMC* [2007] QB 462, *Professional Standards Authority v HCPC and AR* [2020] EWHC 1906*, Cohen v General Medical Council* [2008] EWHC 581 (Admin) , *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin), in respect of impairment.

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 Nalwamba's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Nalwamba's actions amounted to breaches of the Code. Specifically:

> ***"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:*
> ***2.1** work in partnership with people to make sure you deliver care effectively*

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*

3.4 *act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*

8 Work co-operatively

To achieve this, you must:

8.2 *maintain effective communication with colleagues*

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:

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

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

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*

13.4 *take account of your own personal safety as well as the safety of people in your care*

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

To achieve this, you must

19.3 *keep to and promote recommended practice in relation to controlling and preventing infection*

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

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*

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

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first"*

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

The panel considered whether each charge individually amounted to misconduct.

Charges 1a and 1b

The panel took into account that Miss Nalwamba was the nurse in charge, in a position of seniority and leadership, who was responsible for the care of vulnerable residents in the Home. The panel determined that by moving Resident B from the floor by picking him up under his arms and before completing the appropriate observations, she breached the Home's moving and handling policy. The panel took into account that Miss Nalwamba had undertaken moving and handling training. Resident B informed Miss Nalwamba that he

was in pain at the time, however she failed to assess him and proceeded to move him. Miss Nalwamba's actions at charge 1a and 1b put Resident B at a real risk of significant harm having not undertaken the appropriate observations and having utilised incorrect manual handling techniques. The panel determined that Miss Nalwamba's actions at charges 1a and 1b were a significant departure from the standards expected of a Registered Nurse and therefore amounted to misconduct.

Charges 2a and 5c

The panel took into account that Miss Nalwamba was the nurse in charge, in a position of seniority and leadership, who was responsible for the care of vulnerable residents in the Home. However, Miss Nalwamba failed to provide the appropriate care to Resident A in that she did not adhere to the correct standards regarding wound management as detailed in the Home's policy. Furthermore, Miss Nalwamba failed to reposition one or more of the five residents as required. The panel determined that Miss Nalwamba breached a fundamental tenet of the nursing profession in the she failed to preserve residents' safety and put numerous residents at risk of significant harm. In particular the panel noted that on one occasion she failed to ensure that a resident was repositioned during her shift, which resulted in that resident not being repositioned for a period of 13 hours. The panel determined that Miss Nalwamba's actions at charges 2a and 5c were significant departures from the standards expected of a Registered Nurse and therefore amounted to misconduct.

Charges 2b, 2c, 5e and 5f

The panel took into account that Miss Nalwamba was the nurse in charge, in a position of seniority and leadership, who was responsible for the care of vulnerable residents in the Home. The panel took into account that Miss Nalwamba had knowledge of the iCare system. The panel was of the view that by failing to maintain accurate records for the residents and not reviewing or taking any action in respect of the iCare system Miss Nalwamba compromised the care of residents and put them at real risk of significant harm. The panel took into consideration that there was no evidence of contextual circumstances which would provide any explanation as to Miss Nalwamba's failings. The panel determined that Miss Nalwamba's actions at charges 2b, 2c, 5e and 5f were significant

departures from the standards expected of a Registered Nurse and therefore amounted to misconduct.

Charge 3

The panel took into account that Miss Nalwamba was the nurse in charge, in a position of seniority and leadership, who was responsible for the care of vulnerable residents in the Home as well as the staff. The panel had regard to the fact that Colleague 1 was a Registered Nurse at the time and therefore Miss Nalwamba's statement *"no, you don't work as a carer"* was factually correct. The panel was of the view that Miss Nalwamba's conduct, at charge 3 may give rise to attitudinal concerns given the context in which the comment was made and in light of the pattern of behaviour evidenced by the other charges. However, the panel determined when considering charge 3 individually it was not sufficiently serious to be considered deplorable by fellow practitioners. Accordingly, the panel determined that charge 3 does not amount to misconduct.

Charges 4a, 4b, 4c and 5c

The panel took into account that Miss Nalwamba was the nurse in charge, in a position of seniority, who was responsible for the care of vulnerable residents in the Home as well as the staff. The panel had regard to the fact that the Home had a clear policy in respect of sleeping whilst on duty and the shift was even referred to by Witness 1 as a *'waking'* night duty. Additionally, the panel took into account that Miss Nalwamba had been informed after the incident in November 2020 that she was not allowed to sleep on duty. The panel determined that in watching films and sleeping whilst on duty, Miss Nalwamba failed to carry out her duties in respect of monitoring and caring for residents, supporting and supervising her colleagues. Miss Nalwamba's actions therefore put residents at real risk of significant harm as she was not able to carry out her duties. The panel took into account that this was not a single isolated incident and there was a pattern of said behaviour. The panel noted that on one particular occasion Miss Nalwamba was witnessed to be asleep for a six-hour period whilst on duty. The panel determined that Miss Nalwamba's actions at charges 4a, 4b, 4c and 5c were significant departures from the standards expected of a Registered Nurse and therefore amounted to misconduct.

Charge 5d

The panel took into account that Miss Nalwamba was the nurse in charge, in a position of seniority and leadership, who was responsible for the care of vulnerable residents in the Home. The panel had regard to the fact that by failing to adequately and comprehensively review residents' care plans Miss Nalwamba put residents at a real risk of significant harm in that residents' current care needs contained in the records were not complete/accurate. The panel took into account that this also may have affected the continuity of the care the residents received. The panel determined that Miss Nalwamba's actions at charge 5 were a significant departure from the standards expected of a Registered Nurse and therefore amounted to misconduct.

Collective misconduct

The panel when considering all the charges collectively, determined that there was a pattern of negligent behaviour from Miss Nalwamba in respect of resident care and her responsibilities as the nurse in charge, in a position of seniority and leadership. The panel determined that Miss Nalwamba's conduct demonstrates a pattern of deep-seated attitudinal concerns. The panel therefore found that Miss Nalwamba'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 Nalwamba's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 3 March 2025, 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. 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/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

d) *…*

The panel was satisfied that the first three limbs of the *Grant* test are engaged.

The panel found that residents were put at real risk of physical and/or psychological harm as a result of Miss Nalwamba's misconduct. In particular due to Miss Nalwamba's failure to review and or change Resident A's dressing she delayed their wound from healing and put them at risk of infection. Furthermore, in failing to appropriately assess Resident B after he had an unwitnessed fall and then incorrectly handling him, Miss Nalwamba put Resident B at risk of significant harm. The panel found that all resident's in the Home were at risk of harm when Miss Nalwamba absented herself from duty by sleeping and watching films.

The panel determined that Miss Nalwamba's misconduct is serious and breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. In reaching this decision the panel took into account that Miss Nalwamba's misconduct demonstrated a repeated pattern of negligent behaviour which put residents and colleagues at risk of harm and did not promote professionalism and trust.

The panel next considered the principles established in the case of *Cohen.*

> *"Is the conduct easily remediable, has it been remedied and is it highly unlikely to be repeated?"*

The panel determined that there are some concerns which relate to discrete identifiable areas of Miss Nalwamba's clinical practice which could be addressed through retraining. However, as previously identified there is a pattern of repeated negligent behaviour. Miss Nalwamba demonstrated a disregard for residents' welfare and her responsibilities as the nurse in charge, which is indicative of attitudinal concerns. The panel took into account that attitudinal concerns are inherently difficult to remediate and therefore determined that Miss Nalwamba's conduct is not easily remediable.

The panel carefully considered the evidence before it in determining whether or not Miss Nalwamba has taken steps to strengthen her practice. The panel took into account that Miss Nalwamba had undertaken some relevant training on 10 September 2023. However, the panel noted that the four training courses were undertaken on the same day and were e-learning courses. The panel took into account that Miss Nalwamba has been employed by Sue Ryder, as a Registered Nurse, since the concerns arose, from 19 August 2021 to 30 June 2023. The panel had regard to the fact that no further concerns were raised during that period of employment. However, the panel noted that it had no information before it in respect of Miss Nalwamba's employment or practice since June 2023. The panel had no evidence before it, such as positive testimonials, to demonstrate that Miss Nalwamba has implemented her learning into her practice and sufficiently addressed the areas of regulatory concern.

Regarding insight, the panel considered that Miss Nalwamba previously made admissions to some of the concerns. She has also acknowledged some of her wrongdoing and apologised for some of her misconduct. However, Miss Nalwamba has not demonstrated a sufficient understanding of how her actions put residents and her colleagues at risk of harm. Additionally, she has not demonstrated a sufficient understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. Furthermore, she has not demonstrated how she would handle a similar situation differently in the future. The panel therefore concluded that Miss Nalwamba's insight remains limited at this time.

The panel determined that in the absence of sufficient insight and remediation there is a risk of repetition and consequently a real risk of significant harm, especially in light of the attitudinal concerns previously identified. 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. The panel was of the view that the public's trust and confidence would be undermined if a finding of current impairment was not made in respect of Miss Nalwamba's fitness to practice. In reaching this decision the panel took into account that Miss Nalwamba's insight is limited at this time, she has not sufficiently remediated the areas of regulatory concern and there is evidence of attitudinal concerns. The panel concluded that a finding of impairment is required in order to maintain the public's trust and confidence in the profession and the NMC, and to declare and uphold the standard of conduct expected of a Registered Nurse.

The panel was not satisfied that Miss Nalwamba is currently able to practise kindly, safely and professionally.

Having regard to all of the above, the panel concluded that Miss Nalwamba'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 Nalwamba off the register. The effect of this order is that the NMC register will show that Miss Nalwamba 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) and the Code published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

The NMC advised Miss Nalwamba, in the Notice of Hearing, dated 29 July 2025, that it would seek the imposition of a striking off order if it found her fitness to practise currently impaired.

The NMC outlined the aggravating and mitigating features of the case.

The NMC submitted that taking no further action or a caution order is not the appropriate or proportionate order given the seriousness of the facts found proved and the attitudinal nature of the concerns. Furthermore, taking no action or a caution order would not sufficiently protect the public or satisfy the public interest considerations.

The NMC submitted that a conditions of practice order would also not be sufficient to protect the public and maintain public confidence in the profession and the NMC. There are no practical conditions which could be formulated especially in light of the nature and seriousness of the concerns which indicate an attitudinal problem.

Regarding a suspension order, the NMC submitted that the concerns in this case are serious and demonstrate a deep-seated attitudinal issue. This is not a case of a one-off isolated event and there is no evidence that Miss Nalwamba has insight into her conduct or has undertaken sufficient remediation. The NMC submitted that there remains a significant risk of repetition and therefore a suspension order is not appropriate. Miss Nalwamba's misconduct is fundamentally incompatible with continued registration.

The NMC therefore submitted that a striking off order is the appropriate and proportionate order. Miss Nalwamba has not shown sufficient insight into the seriousness of the concerns and the impact her actions could have had on both residents, her colleagues and the public's confidence in the nursing profession. The NMC submitted that without sufficient evidence of remediation and insight, Miss Nalwamba's behaviour is fundamentally incompatible with remaining on the register.

The NMC submitted that the concerns raise fundamental concerns about Miss Nalwamba's professionalism. The concerns are difficult to address or put right and constitute a serious breach of nursing standards, and therefore a striking off order is the appropriate sanction. The NMC submitted that public confidence in the profession could only be maintained by removing Miss Nalwamba from the register.

Decision and reasons on sanction

Having found Miss Nalwamba'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 responsibility in that Miss Nalwamba was in a position of seniority as the nurse in charge on the night shifts
- Limited meaningful remorse and insight into failings.
- Limited evidence of remediation/strengthening of practice.
- A pattern of misconduct over a period of time.
- Concerns relating to both clinical failings and attitudinal concerns.
- Conduct which put vulnerable residents at risk of suffering significant harm.
- Miss Nalwamba was previously subject to an improvement plan which raised similar concerns.

The panel also took into account the following mitigating features:

- Some admissions made during local investigation in relation to charges 1 and 2.

The panel took into account Miss Nalwamba's personal circumstances at the time.[PRIVATE]. The panel therefore gave limited weight to Miss Nalwamba's personal circumstances in relation to mitigating factors.

The panel next considered what sanction, if any, to impose. The panel concluded that taking no action would not be proportionate or appropriate in view of the seriousness of the case and the attitudinal concerns identified. The panel decided that taking no action would not sufficiently protect the public or adequately address the public interest concerns previously identified.

The panel 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 Nalwamba's practice would not be appropriate or proportionate

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 Nalwamba's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the nature and seriousness of the facts found proved and the attitudinal concerns previously identified. The panel decided that imposing a caution order would not sufficiently protect the public or adequately address the public interest concerns previously identified.

The panel next considered whether placing conditions of practice on Miss Nalwamba's registration would be a proportionate and appropriate sanction. The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case, involving wide ranging clinical concerns as well as attitudinal concerns. The panel determined that the misconduct identified in this case was not something that can be addressed through retraining in light of the attitudinal concerns and the limited evidence of insight and remediation. The panel also took into consideration that due to Miss Nalwamba's lack of engagement there is no evidence that she would be willing to comply with conditions. Furthermore, the panel concluded that the placing of conditions on Miss Nalwamba's registration would not sufficiently protect the public or adequately address the public interest concerns previously identified.

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;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel was of the view that the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a Registered Nurse. The panel

determined that Miss Nalwamba's misconduct did not relate to a single instance, but demonstrated a pattern of negligent behaviour, involving wide-ranging clinical concerns, over an extended period of time. The panel concluded that Miss Nalwamba's misconduct demonstrated a disregard to residents' safety and welfare, as well as her own responsibilities as the nurse in charge, in a position of seniority and leadership. The panel took into account Miss Nalwamba's blatant and repeated disregard for policies and procedures which were in place to safeguard residents to be particularly serious.

In the absence of sufficient insight and remediation the panel determined that Miss Nalwamba's misconduct evidenced deep-seated attitudinal problems. The panel took into account that there was no evidence of repetition of the behaviour since the incident, however the panel noted that it had no evidence in relation to Miss Nalwamba's practice since June 2023. The panel had regard to its previous findings in relation to the nature and seriousness of the facts found proved, Miss Nalwamba's limited insight and lack of sufficient remediation. The panel therefore determined that Miss Nalwamba does pose a significant risk of repeating this behaviour at this time.

The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Nalwamba's actions is fundamentally incompatible with her remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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 determined that Miss Nalwamba's actions were significant departures from the standards expected of a Registered Nurse and raise fundamental questions about her professionalism. In reaching this decision the panel took into account the wide-ranging nature and seriousness of the facts found proved involving both clinical and attitudinal concerns. The panel concluded that to allow Miss Nalwamba to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel therefore determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Nalwamba'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 standards of conduct and behaviour required of a Registered Nurse.

This will be confirmed to Miss Nalwamba in writing.

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 Nalwamba's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by the NMC.

The NMC invited the panel to impose an 18-month suspension order in order to protect the public and address the public interest during the period of any appeal.

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 in order to protect the public and address the public interest concerns previously identified during the period of any appeal.

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

That concludes this determination.