Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 12 August 2026 – Friday, 21 August 2026

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

Name of Registrant:	**Uzoamaka Okereke**	
NMC PIN:	22G1664O	
Part(s) of the register:	Registered Nurse – Adult RNA – 27 July 2022	
Relevant Location:	Essex	
Type of case:	Misconduct	
Panel members:	Paul O'Connor Rashmika Shah Marilyn Norman	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Charlene Bernard	
Hearings Coordinator:	Clara Federizo (12 August 2026) Max Buadi (13 – 21 August 2026)	
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter	
Mrs Okereke:	Present and not represented	
Facts Admitted:	Charges 3b, 3c, 3d, 4, 5a, 5b, 6, 7 and 8	
Facts proved:	Charges 1a, 1b, 1c, 1d, 2a, 2c and 3a	
Facts not proved:	Charge 2b	
Fitness to practise:	Impaired	
Sanction:	**Striking off order**	

Interim order: **Interim suspension order (18 months)**

Details of charge (as amended)

That you, a registered nurse:

1. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    a. Failed to undertake regular observations on Patient A and/or ensure regular observations were being undertaken.
    b. Failed to monitor Patient A's blood sugar levels and/or ensure Patient A's blood sugar levels were being monitored.
    c. Failed to ensure Patient A received oxygen, as required.
    d. Failed to escalate Patient A's deteriorating and/or unresponsive condition.

2. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    a. Failed to accurately record Patient A's NEWS score following a change in his responsiveness level.
    b. Recorded only one entry in Patient A's records, that he was in a '*bad state because he is only responding to voice'*, or words to that effect.
    c. Failed to ensure Patient A's fluid input and output was recorded, as per the requirement of his care plan.

3. Breached your interim order, in that you:

    a. In or around March 2024 failed to provide a copy of your Interim Conditions of Practice Order to your employer Hartford Care, contrary to Condition 8a of your Interim Conditions of Practice Order.

b. In or around March 2024 failed to provide a copy of your Interim Conditions of Practice Order to your employer, WorkTree Solutions Ltd, contrary to Condition 8a of your Interim Conditions of Practice Order.
c. Between 25 March and 22 May 2024 worked for Hartford Care and WorkTree Solutions Ltd contrary to Condition 1 of your Interim Conditions of Practice Order.
d. On one or more occasion between 21 June 2024 and 26 July 2024, worked and/or attempted to work as a registered nurse when you were subject to an Interim Suspension Order.

4. Your conduct at charge 3a and/or charge 3b was dishonest, in that you were seeking to conceal the existence of your Interim Conditions of Practice Order from Hartford Care and/or WorkTree Solutions Limited.

5. Your conduct at charge 3c, in undertaking work as a registered nurse for Hartford Care and WorkTree Solutions Limited, was dishonest in that:

    a. You knew you were to work for one substantive employer only.
    b. You practiced unrestricted as a registered nurse when you knew an Interim Conditions of Practice Order was imposed on your practice on 25 March 2024, restricting your practice.

6. Your conduct at charge 3d was dishonest in that you practised or intended to practice as a registered nurse when you knew that an Interim Suspension Order was imposed on your practice on 24 June 2024.

7. On 12 March 2024 you applied for a role as a registered nurse with Hartford Care stating you had left your most recent employer for *“better remuneration”,* when this was not accurate as you had been dismissed.

8. Your conduct at charge 7 was dishonest in that you were seeking to conceal from Hartford Care that you had been dismissed by your most recent employer.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Radley, on behalf of the Nursing and Midwifery Council ('NMC'), to amend the wording of charges 5b and 7. The proposed amendments were to correct typographical errors and omissions within the charges. For charge 5b, it was to include the word "*order*" and for charge 7, it was to replace the word "*renumeration*" with "*remuneration*". Mr Radley submitted that the proposed amendments would provide clarity to the charges.

The panel noted that charge 5b also required "*your*" to be replaced with "*you*".

You did not object to this application.

The proposed charges would read as follows:

"That you, a registered nurse:

[…]

5. Your conduct at charge 3c, in undertaking work as a registered nurse for Hartford Care and WorkTree Solutions Limited, was dishonest in that:

    a. You knew you were to work for one substantive employer only.

b. You practiced unrestricted as a registered nurse when your ~~r~~ knew an Interim Conditions of Practice **Order** was imposed on your practice on 25 March 2024, restricting your practice.

[…]

7. On 12 March 2024 you applied for a role as a registered nurse with Hartford Care stating you had left your most recent employer for *"better ~~renumeration~~* ***remuneration****"*, when this was not accurate as you had been dismissed.

[…]

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed as these were only to correct typographical and grammatical errors. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy of the charges, which would help you clearly understand the allegations you are facing.

Accordingly, the panel allowed the application to amend the charges.

Background

The charges arose whilst you were employed as a registered nurse by Broomfield Hospital part of Mid and South Essex NHS Foundation Trust (the Trust). You were a Band 5 nurse on the Acute Medical Unit (AMU) until your dismissal in February 2024.

You were referred to the NMC on 1 March 2024 by your Matron at the Trust at the time, in relation to care provided to Patient A on the night shift of 3 to 4 July 2023. During this time, you were subject to a performance improvement plan which was implemented in April 2023, which included escalation of patients.

It is alleged that you failed to take observations and/or ensure they were taken by a healthcare assistant (HCA_ as required in relation to Patient A's care plan (who was suffering from acute kidney failure and urosepsis). You also allegedly failed to take action to escalate Patient A's deterioration, failed to monitor his blood sugar or ensure oxygen was given as required, failed to document in sufficient detail throughout the shift and allegedly did not check that observations were carried out when you delegated such tasks.

Further, it is alleged that when the day staff came on duty on the morning of 4 July 2023, you simply carried on with the handover despite Patient A being very hard to rouse. Patient A was then reviewed and had a NEWS score of 10. The Medical Emergency Team (MET) attended, but Patient A suffered a cardiac arrest and died despite resuscitation attempts.

The Trust conducted a local investigation, and a disciplinary hearing took place on 6 February 2024.

On 1 March 2024, further concerns were raised as you allegedly applied for a position at Worktree Solutions Limited and worked a number of shifts between March and July 2024, despite being subject to an Interim Conditions of Practice Order and also later when an Interim Suspension Order was imposed.

You also allegedly worked at Hartford Care from 15 April 2024, whilst your Interim Conditions of Practice Order was in place and did not disclose this to Hartford Care until 20 May 2024. You then resigned on 22 May 2024.

Decision and reasons on application to admit Ms Sinclair's email response to the panel's enquiry

Before Ms Sinclair concluded her evidence, the panel noted that there was no fluid input and output chart for Patient A for 3 and 4 July 2023 before it in evidence. The panel therefore asked Ms Sinclair whether she could make enquiries as to whether such a chart was available.

Mr Radley and you did not object to the panel's request.

The panel accepted the advice of the legal assessor, who referred it to the NMC Guidance entitled, '*Directing further investigation during a hearing'* (reference DMA-5).

The panel subsequently received an email from Ms Sinclair, dated 13 August 2026, in response to its request. Ms Sinclair informed the panel that she had reviewed all of the patient notes dating back to 2019 on the Acute Care Portal but had been unable to find any fluid chart for Patient A.

The panel considered of its own motion whether to admit Ms Sinclair's email into evidence pursuant to Rule 31 of the Rules.

Neither you nor Mr Radley objected to this.

The panel accepted the advice of the legal assessor.

The panel considered that Patient A's fluid input and output chart was relevant to the matters before it. However, Ms Sinclair's response stated that she had been unable to "*find any fluid chart*". The panel considered that no conclusion could properly be drawn from this response as to whether a fluid chart had existed or whether it was otherwise available.

In light of the limited evidential value of Ms Sinclair's response, the panel determined that it would be unfair in the circumstances to admit the email into evidence.

The panel therefore determined not to admit Ms Sinclair's email into evidence.

Decision and reasons on application to provide special measures for Person B

The panel heard an application made by Mr Radley pursuant to Rule 31 of the Rules in relation to Person B, the daughter of Patient A. He informed the panel that Person B was being supported by the NMC Witness Support Service and that one of her concerns was that she did not wish to see you while giving evidence.

Mr Radley submitted that, as a result, your camera should be turned off during Person B's evidence so that she would not have to see you while giving evidence. He submitted that this would not prevent you from participating in the hearing, as you would still be able to hear the evidence being given and you would still be able to see all participants. He further submitted that no adverse inference should be drawn from the arrangements for Person B to give evidence in this way and that the measure would enable Person B to give her best evidence.

In relation to your ability to challenge Person B's evidence, Mr Radley informed the panel that the NMC had been preparing for UNISON to represent you and, accordingly, no alternative measures had been put in place. He submitted that, as you were no longer represented, it would now fall to you to challenge Person B's evidence directly. He

submitted that this would be wholly inappropriate in circumstances where you had been nursing Patient A at the time of his death.

Mr Radley submitted that special counsel could be appointed to challenge Person B's evidence on your behalf, but acknowledged that this would be costly and time-consuming. As an alternative, he submitted that any questions you wished to ask Person B could be put to her by the panel. He submitted that this would provide a fair and balanced approach, with no detriment to you, while also being fair and reasonable to Person B.

A number of other special measures were requested by Mr Radley to accommodate the needs of Person B, listed in a document provided to the panel entitled "*Person B Reasonable Adjustments*".

You did not object to either application.

The panel accepted the advice of the legal assessor.

The panel granted the applications and was satisfied that the proposed arrangements were fair, balanced, just and reasonable and no prejudice would be caused to you. It was also satisfied that these measures would enable Person B to give their best evidence.

In relation to the questions you wished to ask Person B, the panel advised you to review Person B's witness statement, alongside her oral evidence and consider whether any questions arose from it.

The panel determined that it would review the questions you proposed before putting them to Person B on your behalf.

Decision and reasons on application to admit the witness statements of Ms Aparna Nagaram and Ms Shilpa Ramesh

Before the close of the NMC's case on the facts, the panel heard an application made by Mr Radley under Rule 31 of the Rules regarding the written statements of Ms Aparna Nagaram and Ms Shilpa Ramesh. During case management, these witness statements had been agreed.

Mr Radley submitted that the witness statements of Ms Nagaram and Ms Ramesh can either be read into the record or alternatively as both you and the panel have had sight of both witness statements, they can be included in the case.

Mr Radley submitted that this is a matter for the panel.

You had no objection to the application.

The panel accepted the advice of the legal assessor.

The panel bore in mind that all parties have had the opportunity to make comments with regards to the written statements of Ms Nagaram and Ms Ramesh. It also bore in mind that you had no objection to the application. It decided to accept the written statements of Ms Nagaram and Ms Ramesh.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made full admissions to charges 3b, 3c, 3d, 4, 5a, 5b, 6, 7 and 8.

The panel therefore finds charges 3b, 3c, 3d, 4, 5a, 5b, 6, 7 and 8 proved in their entirety, by way of your admissions.

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

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:

- Marianne Horne: The Investigation Officer at the Trust, at the relevant time;
- Caroline Sinclair: Junior Sister on AMU at the Trust and the Nurse in Charge on the night of 3 to 4 July 2023.
- Chloe Adams: Senior Sister on the AMU at the Trust;
- Person B: Daughter of Patient A;
- Tracy Kirby: People and Culture Manager at Hartford Care.

The panel also heard evidence from you under affirmation.

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

1. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    a. Failed to undertake regular observations on Patient A and/or ensure regular observations were being undertaken.

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms Horne and your evidence.

In order to find this charge proved, the panel had to be satisfied that you had a duty to undertake regular observations of Patient A and/or to ensure that regular observations were undertaken. The panel reminded itself that a "*failure*", as alleged in the charge, required evidence of a positive duty to act as alleged, together with evidence that the duty had been breached.

The panel bore in mind that there did not appear to be any dispute that Patient A was a patient under your care during the night shift of 3 to 4 July 2023.

The panel took account of your job description while working in the AMU at Broomfield Hospital. Under the heading *"Overview of Responsibilities"*, there was a sub-heading entitled "*Clinical Function*", which stated that you were required *"to consistently organise and deliver individualised patient care, ensuring patients physical, social and psychological needs are met".* Under the sub-heading *"Management Responsibility"*, the job description further stated that you were required to *"be accountable for own practice*

and for the delegation of care given to more junior colleagues, support workers and students."

In light of this, the panel was satisfied that such a duty existed.

Ms Horne stated in her witness statement that you had failed to ensure that appropriate observations of Patient A were completed. She referred the panel to Patient A's Vital Pac records, which showed that at 22:37 on 3 July 2023, he had a National Early Warning Score (NEWS) score of 6. Ms Horne explained that, as a result of this score, the observation protocol was automatically changed to require hourly observations. However, the next observations were not recorded until 01:35 on 4 July 2023.

The panel then took account of the Trust's "*NEWS2 Escalation of a Deteriorating Adult*" Policy. It noted that a NEWS score of 5 to 6 indicated that the patient was at moderate risk and that physiological observations should consequently be undertaken hourly.

The panel considered Patient A's Vital Pac records and noted that a NEWS score of 1 had been recorded at 13:53 on 3 July 2023, followed by a NEWS score of 6 later the same day at 22:37. The panel bore in mind that, at this point, Patient A's condition had deteriorated and therefore he should have been identified as being at moderate risk and that hourly observations should therefore have been undertaken. However, the next observation was not recorded until 01:35 on 4 July 2023.

The panel further noted that a NEWS score of 6 was recorded at 06:25 on 4 July 2023. In accordance with the "*NEWS2 Escalation of a Deteriorating Adult*" Policy, this again required hourly physiological observations. However, the next observation was not recorded until 08:13 on 4 July 2023.

In your oral evidence, you stated that during the night shift of 3 to 4 July 2023, Petra Sztano, a healthcare assistant, was assigned to work with you. You explained that, following handover, you delegated patient observation tasks to Ms Sztano, whom you

described as experienced, having worked in the AMU for approximately four years. You further stated that Ms Sztano verbally confirmed to you that she had undertaken the observations.

The panel noted that the initials recorded against the NEWS score of 6 at 22:37 on 3 July 2023 were those of Ms Sztano.

This was consistent with Ms Horne's investigation for the Trust. In her witness statement, she stated that you had delegated the observations to Ms Sztano. However, she also stated that she would have expected you to check the Vital Pac records yourself so that you could assess your patients. In her view, while you had correctly delegated the observations, you had not maintained your accountability of ensuring that observations were correctly made and recorded and you omitted to check the patients yourself.

Ms Horne further stated that when Ms Sztano asked you about undertaking hourly observations, you instructed her to continue with four-hourly observations regardless of the prompts generated by the Vital Pac system.

In response to questions from the panel, Ms Horne stated that she would have expected a registered nurse to undertake hourly observations following the recording of a NEWS score of 6.

The panel was satisfied that, although you had delegated the observations to Ms Sztano, she did not undertake the required hourly observations following the recording of a NEWS score of 6, as required by the "*NEWS2 Escalation of a Deteriorating Adult*" Policy.

The panel was further satisfied that, as the registered nurse responsible for Patient A, you had a duty to ensure that regular observations were undertaken. The panel bore in mind that, although you were entitled to delegate tasks, your job description expressly stated that you were accountable for the delegation of care provided by more junior colleagues.

In the panel's view, this accountability required you to exercise appropriate oversight of the care that you had delegated.

The panel therefore found that, following the NEWS score of 6 recorded at 22:37 on 3 July 2023, you had a responsibility to ensure that Patient A received hourly observations. The next observation was not recorded until 01:35 on 4 July 2023. Similarly, following the further NEWS score of 6 recorded at 06:25 on 4 July 2023, you had a responsibility to ensure that hourly observations continued, yet the next observation was not recorded until 08:13 on 4 July 2023.

The panel was therefore satisfied that, on both occasions, you failed to ensure that the required hourly observations were undertaken. The panel considered that this was a failure on your part to fulfil the responsibility that remained with you notwithstanding the delegation of the task to Ms Sztano.

The panel therefore found this sub-charge proved.

Charge 1b

1. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    b. Failed to monitor Patient A's blood sugar levels and/or ensure Patient A's blood sugar levels were being monitored.

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms Horne, Ms Adams and your evidence.

For the same reasons as set out in sub-charge 1a, the panel was satisfied that you had a duty to monitor Patient A's blood sugar levels and/or to ensure that Patient A's blood

sugar levels were being monitored. The panel therefore went on to consider whether you had failed to fulfil that duty.

Ms Horne stated in her witness statement that Patient A was due to have his blood sugar levels monitored overnight, but there was no record of any such monitoring having been completed. She also stated that you had documented in the nursing notes that the HCA, Ms Sztano, had been asked to undertake the blood sugar monitoring, but that no results had been recorded. Ms Horne stated that there was no evidence that Patient A's blood sugar levels had been monitored by either you or Ms Sztano. This was also confirmed by Ms Adams in her witness statement.

The panel noted that there was a clear medical plan in relation to Patient A's blood sugar monitoring. It took account of the "*Medical Notes*", which stated that Patient A's blood sugar levels were to be checked hourly for four hours and, if stable, thereafter every six hours.

The panel then considered Patient A's two Vital Pac records. It noted that the records contained two blood glucose measurements more than 18 hours apart. At 13:53 on 3 July 2023, Patient A's glucose level was recorded as 3.4 mmol/L, and at 08:13 on 4 July 2023, it was recorded as 4.4 mmol/L. There was, however, no record of any blood glucose measurements between those times, including during the night shift of 3 to 4 July 2023.

The panel also took account of Patient A's nursing notes. An entry dated 3 July 2023 at 18:11 recorded, "*BM checked 11.0 mmol/L*". The panel noted that this measurement had been taken before the commencement of the night shift in question. It could not identify any further record of Patient A's blood sugar level during the night shift of 3 to 4 July 2023.

In your oral evidence, you stated that you had delegated the task of monitoring Patient A's blood sugar levels to Ms Sztano and that she had told you she had undertaken the observations. However, you also noted that, during the investigation undertaken by Ms Horne, Ms Sztano stated that she did not have a "*barcode*", which was required in order to

record Patient A's blood sugar levels. You said that Ms Sztano had not raised this issue with you at any point during the night shift. Furthermore, you explained to the panel in your oral evidence that you and other nurses each had your own barcodes which could have been shared if necessary. You also accepted that you did not check whether the blood sugar levels had in fact been recorded and only became aware that they had not been recorded in the morning.

As with sub-charge 1a, the panel was satisfied that you had delegated the task of monitoring Patient A's blood sugar levels to Ms Sztano. However, the panel found that the required monitoring was not undertaken in accordance with the plan set out in the Medical Notes.

The panel bore in mind that your job description expressly stated that you were accountable for the delegation of care provided by more junior colleagues. The panel considered that this accountability required you to exercise appropriate oversight of the care that you had delegated, including ensuring that the delegated task had been completed in accordance with Patient A's care requirements.

The panel therefore concluded that, although you had delegated the task of monitoring Patient A's blood sugar levels to Ms Sztano, responsibility for ensuring that the monitoring was undertaken in accordance with the medical plan remained with you. The panel was satisfied that, on the night of 3 to 4 July 2023, you failed to ensure that Patient A's blood sugar levels were monitored as required during the night shift of 3 to 4 July 2023.

The panel therefore found this sub-charge proved.

Charge 1c

1. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    c. Failed to ensure Patient A received oxygen, as required.

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms Horne and your evidence.

For the same reasons as set out in sub-charge 1a, the panel was satisfied that you had a duty to ensure that Patient A received oxygen as required. The panel therefore went on to consider whether you had failed to fulfil that duty.

The panel took account of Patient A's care plan in relation to his oxygen requirements. The panel had sight of the medical prescription dated 3 July 2023 that stated that if the oxygen level fell below 94% that oxygen should be administered "*PRN*" (as needed) to maintain an oxygen level of between 94% and 98%.

The panel then considered Patient A's Vital Pac records. It noted that at 23:37 on 3 July 2023, Patient A's oxygen saturation was recorded as 92%. At 01:35 on 4 July 2023, it was recorded as 94%, and at 06:25 on 4 July 2023, it was recorded as 91%. The panel noted that, on two occasions, Patient A's oxygen saturation fell below the lower limit of his prescribed target range, yet there was no record of oxygen being administered.

In cross-examination, you stated that the last observation you had personally undertaken was the recording of an oxygen saturation of 94% at 01:35 on 4 July 2023. When asked why oxygen had not been administered when Patient A's oxygen saturation fell below 94%, you stated that you had not seen his oxygen saturation level after you had made the 01:35 recording.

You were then asked whether, as a result, you had failed to keep Patient A's oxygen saturation at the required level. You answered, "*yes*".

The panel therefore found that, on two occasions during the night shift, Patient A's oxygen saturation fell below his prescribed target range and there was no evidence that oxygen was administered as required. The panel was satisfied, on the basis of your own evidence, on the night of 3 to 4 July 2023 that you had failed to ensure Patient A received oxygen, as required.

The panel therefore found this sub-charge proved.

Charge 1d

1. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    d. Failed to escalate Patient A's deteriorating and/or unresponsive condition.

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms Horne, Ms Adams and your evidence.

For the same reasons as set out in sub-charge 1a, the panel was satisfied that you had a duty to escalate Patient A's deteriorating and/or unresponsive condition. The panel therefore went on to consider whether you had failed to fulfil that duty.

Ms Adams, in her witness statement, referred to the "*NEWS2 Escalation of a Deteriorating Adult*" Policy. She explained that the NEWS policy contains a grid setting out specific criteria and that, where observations meet criteria outside the prescribed boundaries, the patient must be escalated to the nurse in charge and doctors so that appropriate intervention and treatment can be provided. She further stated that any single score of 3, or an overall score of 5 or above, should be escalated.

The panel took account of the "*NEWS2 Escalation of a Deteriorating Adult*" Policy. Under the sub-heading "*Escalation graded response*", the policy stated that a NEWS score of 3 and scores of 5 to 6 were regarded as indicating moderate risk. It further stated that escalation must be made to the registered nurse/senior nurse on duty, with additional escalation to the outreach team.

The panel also noted that the policy stated that, where there was no response from the Medical Team or Outreach within the specified timeframe following the initial escalation, the registered nurse should re-contact the relevant individuals or escalate the patient to a more senior doctor.

In your evidence to the panel, you stated that, when Patient A recorded a NEWS score of 6 at 22:37 on 3 July 2023, you attempted to escalate the matter to a doctor on two occasions around 22:00 but did not wait for a response.

The panel also noted that during your investigation interview of 20 September 2023, you stated that you could not remember whether you had escalated the matter to a doctor. The panel bore in mind that this differed from the evidence you gave to the panel, in which you stated that you had attempted to contact a doctor twice. The panel therefore questioned the reliability of your account in light of this discrepancy.

The panel further noted the evidence of Person B, Patient A's daughter, who was present with him in his room during the night in question. In her witness statement, she stated that she had asked for help from you on numerous occasions throughout the night, but that no one came to the room to check on Patient A.

The panel considered that the absence of any evidence documenting an escalation to the Medical Team or Outreach was significant.

The panel further noted in your oral evidence you stated that you did not speak to the nurse in charge, Ms Sinclair, regarding Patient A's deteriorating condition.

The panel therefore concluded that, even accepting that you may have initially attempted to contact a doctor, there was no evidence that you completed the escalation process required by the policy. In particular, there was no evidence that you escalated Patient A to the senior nurse on duty or re-contacted the doctor, or had a discussion with the Outreach team in accordance with the "*NEWS2 Escalation of a Deteriorating Adult*" Policy.

In light of the above, the panel concluded that on the night of 3 to 4 July 2023, you failed to escalate Patient A's deteriorating and/or unresponsive condition.

The panel therefore found this sub-charge proved.

Charge 2a

2. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    a. Failed to accurately record Patient A's NEWS score following a change in his responsiveness level.

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms Horne, Ms Adams and your evidence.

For the same reasons as set out in sub-charge 1a, the panel was satisfied that you had a duty to ensure that Patient A's NEWS score was accurately recorded following a change in his responsiveness level. The panel therefore went on to consider whether you had failed to fulfil that duty.

Ms Horne, in her witness statement, stated that Patient A's last recorded NEWS score had been 1 and that, at 22:37 on 3 July 2023, HCA Ms Sztano recorded observations which

showed an increase in Patient A's NEWS score to 6. Ms Horne stated that you subsequently recorded in the nursing notes that Patient A had been taken over in a "*bad state because he is only responding to voice*". She further stated that neither you nor Ms Sztano reflected the change in Patient A's level of responsiveness when completing the NEWS2 assessment and that, as a result, the NEWS score was incorrectly calculated.

Ms Adams, in her witness statement, stated that there had been a discussion regarding Patient A's level of alertness, with the day-shift nurse stating that he was not alert. However, Ms Sztano had recorded at 06:25 on 4 July 2023 on the NEWS2 chart that Patient A was alert, resulting in a NEWS score of 6. Ms Adams stated that, if Patient A was not alert, his NEWS score should have been significantly higher, at least 9 or 10. She explained that an alert patient would receive a NEWS score of 0 for consciousness, whereas a patient who was responsive only to pain or voice, or who was unresponsive, would automatically receive a NEWS score of 3 for their level of consciousness.

The panel took account of the "*NEWS2 Escalation of a Deteriorating Adult*" Policy and, in particular, "*Appendix 1: NEWS2 National Early Warning Score*". It noted that the table identified "*Alert*" consciousness as corresponding to a NEWS2 score of 0, whereas a reduced level of consciousness attracted a higher score.

The panel bore in mind the evidence of Person B. In her witness statement, she stated that, at one point during the night, Patient A was very drowsy. She stated that, when you entered the room, she told you that Patient A was very drowsy and was not responding when she attempted to speak to him. Later in her statement, Person B stated that she had attempted to call Patient A's name several times, which caused her to become concerned. She stated that she told you Patient A was incoherent and was not responding when she shook his hand.

In her oral evidence, Person B stated that she had been unable to rouse Patient A. She explained that he was not opening his eyes and was unable to communicate with her.

The panel also took account of the nursing notes, in which you recorded that Patient A had been taken over in a *"bad state because he is only responding to voice"*. You also recorded that Patient A's oral medication had been omitted because he was *"at risk of aspiration"*.

The panel considered that both you and Person B had identified that Patient A was not alert and that his level of consciousness had deteriorated. The panel noted that this change in Patient A's level of consciousness was not reflected in the NEWS2 scores recorded during the night of 3 to 4 July 2023.

The panel took account of Patient A's Vital Pac records and noted that Ms Sztano had recorded a NEWS score of 6 at 22:37 on 3 July 2023. However, Patient A's level of consciousness was recorded as "*Alert*" at 22:37 on 3 July 2023 and again at 01:35, 06:25 and 08:13 on 4 July 2023.

The panel bore in mind that your job description expressly stated that you were accountable for the delegation of care provided by more junior colleagues. The panel considered that this accountability required you to exercise appropriate oversight of the care that you had delegated, including ensuring that the observations recorded accurately reflected Patient A's clinical presentation and care requirements.

The panel was therefore satisfied that, having identified and documented that Patient A was only responding to voice, you failed to ensure that this significant change in his level of consciousness was accurately reflected in his NEWS2 assessment. The panel therefore found that Patient A's NEWS2 score was not accurately recorded following the change in his responsiveness level.

The panel therefore found this sub-charge proved.

Charge 2b

2. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    b. Recorded only one entry in Patient A's records, that he was in a '*bad state because he is only responding to voice'*, or words to that effect.

This sub-charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms Horne and your evidence.

Ms Adams, in her witness statement, stated that on 3 July 2023, Patient A was handed over to you and Ms Sztano at 20:00. She stated that, when Patient A recorded a NEWS score of 6 at 22:37 on 3 July 2023, you recorded that he had been taken over in a "*bad state*" because he was only responding to voice. In her oral evidence, Ms Adams stated that she would have expected you to document more information, including Patient A's vital observations and the actions you had taken in response to his condition.

The panel took account of Patient A's nursing notes. It noted that, at 23:00 on 3 July 2023 and 07:00 on 4 July 2023 you recorded the following:

> "*Patient's care confirmed, Obs done & recorded. Patient was taken over in a bad state because he is only responding to voice. Bariatric Bed ordered but not transferred yet - not enough hands available. Patient's oral meds were omitted because he's at risk of aspiration. IV Abx given. IVI running overnight. The HCA said she checked the BM but didn't record it at night but didn't check for this morning. I asked her at night if all the BM's were done and she said yes but I found that none was recorded this morning. Patient is currently at NEWS of 6."*

In your oral evidence, you told the panel that you made a single entry referencing 23:00 on 3 July 2023 and 07:00 on 4 July 2024 where you signed once at the end of the entry. The panel considered the content of this entry. It noted that, although it was a single entry, it contained information about Patient A's observations, his clinical condition, the arrangements for a bariatric bed and the omission of his oral medication due to the identified risk of aspiration.

The panel was of the view that the entry contained more information than is suggested by the wording of the charge. In particular, the panel considered that the charge appeared to suggest that you had recorded little or no information regarding Patient A's condition and the actions taken in response. Having reviewed the entry, the panel was not satisfied that this was an accurate characterisation of what you had recorded.

The panel therefore found this sub-charge not proved.

Charge 2c

2. On the night shift of 3 to 4 July 2023 in respect of Patient A:

    c. Failed to ensure Patient A's fluid input and output was recorded, as per the requirement of his care plan.

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms Horne and your evidence.

For the same reasons as set out in sub-charge 1a, the panel was satisfied that you had a duty to ensure that Patient A's fluid input and output was recorded in accordance with the requirements of his care plan. The panel therefore went on to consider whether you had failed to fulfil that duty.

The panel noted that there was a clear medical plan in relation to Patient A's urine output. It took account of the "Medical Notes" dated 3 July 2023, which stated that the aim was for a urine output of 100ml per hour.

The panel also noted a further instruction requiring a "*Strict input and output chart*", which was underlined, written in capital letters and followed by two exclamation marks.

In addition, the panel took account of Patient A's clinical notes, which contained the medical plan: "*Urinary catheter, Monitor input/output*".

The panel then considered the "*NEWS2 Escalation of a Deteriorating Adult*" Policy. Under the sub-heading "*Urine Output*", paragraph 7.4.2 stated:

> *"If a patient's score is a moderate or high risk priority for deterioration then a fluid management chart must be commenced if not already in use."*

The panel was satisfied that there was a clear requirement for Patient A's fluid input and output to be monitored and recorded. This requirement arose from Patient A's individual medical plan.

In your oral evidence, you stated that a fluid input and output chart should have been commenced on the ward rather than in the AMU. However, you accepted that you did not record Patient A's fluid input and output during the night shift in question.

The panel therefore found that, notwithstanding where the chart should have been commenced, you were responsible for ensuring that Patient A's fluid input and output was monitored and recorded in accordance with his care requirements. The panel was satisfied that you failed to fulfil that duty.

The panel therefore found this sub-charge proved.

Charge 3a

3. Breached your interim order, in that you:

    a. In or around March 2024 failed to provide a copy of your Interim Conditions of Practice Order to your employer Hartford Care, contrary to Condition 8a of your Interim Conditions of Practice Order.

This sub-charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms Kirby and your evidence.

Ms Kirby, in her witness statement, stated that you were offered a role as a registered nurse at Highfield Nursing Home on 12 March 2024 and that an offer letter was sent to you on 13 March 2024. She further stated that you commenced employment at the Home on 15 April 2024. Ms Kirby stated that, during the recruitment process and upon commencing in post, you did not disclose that you were subject to Interim Conditions of Practice Order.

Ms Kirby further stated that an NMC PIN check was undertaken on 14 March 2024 and that there were no restrictions on your practice recorded at that time. She stated that, on 20 May 2024, you voluntarily disclosed during a verbal conversation with the Acting Home Manager, Mr Oliver John Kearney, that you were subject to an NMC investigation. However, you did not provide any further information or disclose that you were subject to an Interim Conditions of Practice Order.

Ms Kirby reiterated this evidence in her oral evidence. She recalled that, on 20 May 2024, Mr Kearney contacted her to inform her that restrictions had appeared against your NMC PIN and to ask what he should do. Ms Kirby stated that she advised him to obtain further

information. She explained that Mr Kearney subsequently scanned documents he had received from you into your employment file, to which he had access. Ms Kirby stated that she then conducted a further NMC PIN check, at which point the Interim Conditions of Practice Order appeared.

Mr Radley asked Ms Kirby whether, between 25 March 2024, when the Interim Conditions of Practice Order was imposed, and 20 May 2024, when you disclosed the matter to Mr Kearney, the company had been made aware that an interim order had been imposed on your practice. Ms Kirby answered, "*No*".

The panel took account of the Interim Conditions of Practice Order imposed on 25 March 2024. It noted that condition 8(a) stated:

"8. You must immediately give a copy of these conditions to:
a) Any organisation or person you work for."

In your oral evidence, you accepted that you had received the interim conditions of practice order on 25 March 2024. You further accepted that you did not inform your employer of the order until 20 May 2024, by which time you had completed your induction.

The panel therefore noted that there was a period of approximately eight weeks between the imposition of the interim conditions of practice order and your disclosure of the order to your employer. During this period, you had commenced employment at Highfield Nursing Home and had not provided your employer with a copy of the conditions, as required by condition 8(a) of the order.

The panel therefore found this sub-charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts admitted and found proved amount to misconduct and, if so, whether your 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 safely and effectively without restriction.

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

Submissions on misconduct

Mr Radley referred the panel 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*.' He also referred the panel to the cases of *Calhaem v GMC [2007] EWHC 2606 (Admin)* and *Nandi v GMC [2004] EWHC2317 (Admin).*

Mr Radley invited the panel to take the view that the facts found proved amount to misconduct. He directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, your actions amounted to misconduct.

Mr Radley submitted that your failures in caring for Patient A and your behaviour in working subject to an Interim Suspension Order and breaking the conditions of the Interim Conditions of Practice Order fell far short of the standards set out in the Code. He submitted that what you did amounts to serious professional misconduct.

Mr Radley submitted that the conduct found proved are matters at the heart of and fundamental to your practice. He submitted that this was dishonesty, a failure to escalate Patient A's deteriorating condition, failing to carry out basic checks and casting blame on others.

Submissions on impairment

Mr Radley 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).

Mr Radley submitted that all limbs of the Grant test are engaged.

With regards to whether it is likely that the conduct will be repeated, Mr Radley submitted that it can be concluded that you would continue to place your family first irrespective of any restrictions on your practice before the needs of the public. He submitted that you had stated that you did not tell your employer about the Interim Conditions of Practice Order because they may have formed a view and effectively, you feared you would not have been employed.

Mr Radley submitted that this attitude would impact on your ability to practise safely and effectively without restriction resulting in what the NMC suggests is a finding of current

impairment. He submitted that the behaviour is engrained into you and you will not change your ways.

Mr Radley submitted that your conduct contributed to Patient A's deterioration because you did not act on the warning signs. He submitted that this placed Patient A at risk of harm, thereby identifying clear public protection concerns.

Mr Radley submitted that you have failed to uphold proper professional standards and, as a result, public confidence in the profession will be affected if you were permitted to continue to practice following this behaviour.

Mr Radley invited the panel to find that your fitness to practice is currently impaired.

You said that ever since this case started you have been misjudged, misquoted and you are suffering. You said that practicing as a nurse in the United Kingdom is different to practicing as a nurse in your home country.

You said that it is your dream to care for your patients but this dream was cut short due to "*this particular thing which I always regret*." You said that you have never been in this situation since you started practicing as a nurse 20 years ago. You said that you have never had a concern raised against you. You said that it is not in your character to have these kind of concerns against you. You said that you always try to give your best to your patients.

You said that during your period on the AMU, the manager never had concerns about you until this case.

You said that you would choose your family over your work as they come first in your life. You said that you are very proud to say that. You said that this does not prevent you from doing your work and taking care of your patients.

You said that you remember your Band 5 training, the teacher said that the HCAs are liable and can be called to question if they do not do their work.

You said that on the night in question you transferred out six patients and brought in six patients. You said that you therefore managed 13 patients with no support. You said that you understand nursing is about continuity of care and you may have failed to complete the plan of Patient A. You stated that Patient A was not the only patient on the ward and reminded the panel that it was an acute ward.

You said that you may do things differently if you were once again in the same situation. You said that you would supervise the HCA and ensured she did what she was supposed to do or better yet, done it yourself.

You said that the situation taught you to be more careful and to take more responsibility for the work assigned to you. You said that if you cannot do the work, you will say so. You said that this is where you failed as you should have asked for more help on that particular day. You said that you have never been a careless nurse.

You said that you were on a performance plan before that particular day and were trying to fulfil all the requirements of that plan. You said that you would not want anything to come between you and your job but unfortunately these events occurred.

[PRIVATE]. You said that you have never known anything else but being a nurse.

You said that due to your desperation and a lack of understanding, you are being questioned about your dishonesty. You said that you had undertaken other jobs because you were trying to survive. You said that it is sad that your honesty is in question. You said that it was wrong to take other jobs and you apologise. You said that you were seeking help and are left with nothing.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your 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*
>
> ***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*
>
> ***8 Work co-operatively***
> *To achieve this, you must:*
>
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *8.2 maintain effective communication with colleagues*
> *8.5 work with colleagues to preserve the safety of those receiving care*

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

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

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

To achieve this, you must:

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times
To achieve this, you must:

20.1 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
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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.
To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered whether each of the facts found proved amounted to misconduct.

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

In relation to sub-charges 1a, 1b, 1c, 1d, 2a and 2c, the panel was of the view that you exposed Patient A to an unnecessary risk of harm. This was, in part, due to the lack of supervision following your delegation and allocation of work to the HCA in relation to Patient A's observations, and your failure to escalate when the NEWS scores required you to do so.

In the panel's view, observations of a patient known to be critically unwell are important and constitute a basic facet of nursing practice. The panel also took into account that you failed to act on the concerns raised by Person B, did not follow Patient A's medical plan, inaccurately recorded the NEWS score and failed to ensure that Patient A was appropriately observed. Your actions prevented Patient A from receiving the medical care he required and significantly delayed the provision of emergency treatment.

The panel considered that each of these matters, both individually and collectively, were clinically dangerous.

The panel concluded that your actions in relation to sub-charges 1a, 1b, 1c, 1d, 2a and 2c would be regarded as deplorable by fellow practitioners and amounted to serious misconduct.

Sub-charges 3a, 3b, 3c, 3d, 4, 5a and 5b, and charges 6, 7 and 8, relate to your working in breach of interim orders imposed on your practice and the associated dishonesty. In the panel's view, your failure to inform your employer of the Interim Conditions of Practice Order, and your failure to inform a subsequent employer of the Interim Suspension Order, placed patients at potential risk of harm. The panel considered that the interim orders had been imposed to protect patients and that your failure to disclose them undermined that protective purpose.

The panel noted that you worked shifts while knowing that you were subject to an Interim Suspension Order. You accepted that you had concealed the restrictions on your NMC

PIN from your employer and stated that you did so because you did not want your employer to be "*biased*" towards you. The panel bore in mind that the dishonesty was deliberate and prolonged and occurred in relation to two different employers.

The panel concluded that your actions in relation to sub-charges 3a, 3b, 3c, 3d, 4, 5a, 5b and charges 6, 7 and 8 would be regarded as deplorable by fellow practitioners and amounted to serious misconduct.

In light of the above, the panel determined that the charges admitted and found proved, individually and collectively, amounted to a serious departure from the appropriate standards expected of a registered nurse and constituted misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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.'*

For reasons already set out above, the panel considered that limbs a, b c and d were engaged by your misconduct in this case.

The panel found that Patient A was put at an unwarranted risk of harm. This arose from your failure to monitor and escalate Patient A's clinical condition in a manner that is expected of a registered nurse and therefore your actions fell significantly below the standards of safe and effective practice.

The panel also found that your misconduct breached fundamental tenets of the nursing profession as per the Code.

The panel considered that providing safe and effective care to patients is a fundamental requirement of nursing practice and that a failure to meet this standard has the potential to adversely affect public confidence in the nursing profession. The public places trust in nurses to provide safe and appropriate care to patients. Where a nurse fails to practise safely, this may undermine that trust and create doubt about the standards expected of registered nurses. The panel therefore considered that your misconduct had brought the reputation of the nursing profession into disrepute.

The panel was satisfied that public confidence in the nursing profession would be undermined if its regulator did not regard allegations of dishonesty as extremely serious.

The panel recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether you would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the

future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you have provided evidence of insight and remorse.

In relation to insight, the panel took account of your oral submissions and reflective statement. It noted that you had not acknowledged the unwarranted risk of harm or impact that your misconduct posed to Patient A or to the other patients under your care while your NMC PIN was restricted. You had also failed to acknowledge your accountability for overseeing the work of the HCA.

The panel noted that you stated that you had been "*misjudged*" and "*misquoted*". You also stated that you had never previously had concerns raised about your nursing practice. However, the panel bore in mind that you were at the times of the concerns subject to a Performance Improvement Plan. In the panel's view, this suggested that you did not fully acknowledge and recognise your own developmental needs.

In relation to your decision to work while restrictions were imposed on your NMC PIN, the panel noted your explanation that you had not informed your employers of the Interim Order because you did not want them to be biased against you. You also stated that you did not inform one of your employers of the Interim Conditions of Practice Order until you had completed your induction.

You explained that you were the sole provider for your family and needed to secure employment in order to provide for them financially. You stated that you did not consider that working in these circumstances would affect your ability to care for your patients. However, the panel considered that your actions did have an impact on patient care because you failed to inform your employer that your NMC PIN was restricted. The panel considered that the interim orders had been imposed to protect patients and that your failure to disclose them undermined that protective purpose.

The panel was of the view that you appeared to have prioritised your own needs and circumstances over patient care and had failed to give sufficient consideration to the potential risks to patient safety.

The panel noted that you had demonstrated some remorse and had apologised. However, in the panel's view, you had placed the needs of your family above the requirements of the nursing profession.

You did not appear to recognise the consequences of your lack of care towards Patient A. The panel found a lack of recognition of the impact of your misconduct on Patient A, his family, your colleagues or the reputation of the nursing profession. While you provided some examples of how you would approach similar circumstances in the future, the panel considered that these were limited and did not demonstrate a sufficient understanding of the underlying concerns.

In light of the above, the panel determined that you had demonstrated limited insight.

The panel was satisfied that the misconduct relating to sub-charges 1a, 1b, 1c, 1d, 2a and 2c was capable of remediation. However, in relation to sub-charges 3a, 3b, 3c, 3d, 4, 5a and 5b, and charges 6, 7 and 8, the panel noted that misconduct involving dishonesty is often considered less readily remediable than other forms of misconduct, as it can reflect a deep-seated attitudinal problem rather one that can be improved through training and support.

The panel was also of the view that the dishonesty was pre-meditated and demonstrated a concerning pattern of behaviour which appeared to be attitudinal in nature.

The panel therefore carefully considered whether you had taken sufficient steps to strengthen your practice and address the concerns identified.

The panel considered the training certificates you had provided. However, you did not demonstrate how the learning from those courses has been applied to patient care, how that learning had been translated into improvements in your professional practice or satisfy the panel that you could deliver the fundamental aspects of care safely and effectively.

The panel also considered the testimonials you provided. It noted that these appeared to have been provided by previous colleagues and not from recent employers or colleagues. In the panel's view, the testimonials did not appear to have been written with full knowledge of the regulatory concerns arising in this case. While they provided positive evidence of your character, they did not materially assist the panel in assessing your nursing capabilities or whether the regulatory concerns identified had been addressed.

Overall, the panel concluded that there was very limited evidence before it that you had taken meaningful steps to acknowledge, address or remedy the concerns identified in this case. In particular, there was insufficient evidence that you had addressed the attitudinal issues which appeared to underpin the charges in relation to the Interim Order on your NMC PIN and your associated dishonesty.

The panel is of the view that in the absence of sufficient insight, remorse and evidence that you had strengthened your practice in the areas of concern identified by the panel, you were liable to repeat your actions in the future. Were those actions to be repeated, there would be a risk of more patients in your care being placed at an unwarranted exposure to harm. Additionally, there would be further damage to the reputation of the profession and further breaches of fundamental tenets of the profession. 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 was satisfied that, having regard to the nature of the misconduct in this case, *"the need to uphold proper professional standards and public confidence in the profession would be undermined"* if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if your fitness to practise was not found to be impaired and therefore public confidence in the nursing profession would be undermined if you were allowed to practice unrestricted.

For all the above reasons the panel concluded that your fitness to practise is currently impaired by reason of misconduct on both public protection and public interest grounds.

Having regard to all of the above, the panel was satisfied that your 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 you off the register. The effect of this order is that the NMC register will show that you have 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 regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Radley took the panel through the aggravating and mitigating factors he considered to be engaged in this case.

Mr Radley submitted that the clinical concerns in this case, if found alone may not reach the level required to warrant the imposition of a Striking-off Order. He submitted however that in this case the clinical concerns have been compounded by the repeated breaches of the Interim Orders and associated dishonesty which makes this case significantly more serious.

Mr Radley submitted that taking no action or imposing a caution order would not be appropriate due to gravity of the overall circumstances.

With regards to a Conditions of Practice Order, Mr Radley submitted that the dishonesty relates directly to practice in as much as you worked as a nurse while restricted and therefore you were not complying with the protective measures which had been imposed to guard against harm to patients. He submitted that given the gravity of the NMC's concerns, reflected by the rationale of the panel, a Conditions of Practice Order is not a suitable order.

Mr Radley submitted that a Suspension Order would not be appropriate for this case. He submitted that the conduct identified in the panel's findings on impairment recognises aspects of the case that you would find hard to put right, such as dishonesty. He submitted that there is evidence of a deep-seated attitudinal issue and therefore a Suspension Order is not suitable.

Mr Radley submitted that honesty is of central importance to a professional's practice because of the large degree of trust placed in them. Therefore, allegations of dishonesty will almost always put the public at risk of the professional not being trustworthy.

Mr Radley submitted that a deliberate breach of an interim or final order is aggravating, undermines public protection, and calls into question whether you could remain on the register and still comply with any future sanction. He submitted that there is a lack of evidence that your previous behaviour would not be repeated.

Mr Radley invited the panel to impose a Striking-off Order.

You said that ever since this case started, the panel have followed what the NMC suggested. You said that nothing you say would change the outcome.

You said that the NMC have already made a decision on what sanction the panel should impose. You said that you are waiting for the sanction to be confirmed so you can move on with your life. You said that the process has been a “nightmare”.

You said that you brought yourself and your family to the UK to provide a better life. You said “*I will not agree that I did what I did*.”

The Chair informed you that the panel are independent and it has not yet made a decision on sanction.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Patient A's clinical condition deteriorated and his vulnerability increased. Concerns about his presentation were pointed out on a number of occasions by Person B, but you still failed to engage.
- The deliberate and repeated breaches of the interim orders;
- The premeditated and sustained dishonesty to two different employers;
- Limited insight into your dishonesty and its impact on the nursing profession, colleagues and the public;
- Deliberate breaches of the Code;
- Your lack of personal accountability and lack of clear understanding of the seriousness of your actions;

The panel also took into account the following mitigating features:

- Some degree of remorse demonstrated;
- Early admissions to some of the charges prior to and at this hearing;
- Engagement with the NMC process;
- Personal financial hardship.

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

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired*

fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety because of the seriousness of the facts found and your dishonesty. The panel therefore determined that a sanction that does not restrict your practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place conditions of practice on your registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of Practice Order' (Reference: SAN-2c Last Updated: 28/01/2026).

The panel considered that the clinical concerns alone could possibly have been addressed through a Conditions of Practice Order. However, it noted that you had previously been subject to an Interim Conditions of Practice Order, which you failed to adhere to by failing to disclose it to both Hartford Care and WorkTree Solutions Ltd. This resulted in a sustained and repeated period of dishonesty where you concealed it from them. In the panel's view, this behaviour demonstrated deep-seated attitudinal concerns which cannot be addressed by conditions of practice.

Furthermore, given the past breaches of interim orders, the panel had not been presented with any evidence that provided sufficient reassurance that you would comply with a Conditions of Practice Order if one were imposed.

In light of these considerations, the panel determined that, while the clinical concerns may have been capable of being addressed through a Conditions of Practice Order, the identified public interest concerns namely dishonesty, could not be addressed through conditions.

Having regard to the nature and seriousness of your conduct, the panel therefore determined that a Conditions of Practice Order would not be appropriate in the circumstances. The panel was unable to identify any relevant, proportionate, workable and measurable conditions that could adequately address the concerns, protect patients, and uphold professional standards.

The panel went on to consider whether a Suspension Order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a Suspension Order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a Suspension Order. It noted the following list of circumstances that may make a Suspension Order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*

- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel reminded itself that the dishonesty in this case was serious, premeditated, sustained and repeated. You failed to comply with the Interim Orders and continued to work with vulnerable patients despite knowing that you were not permitted to do so. The panel also had regard to the fact that, although the concerns arose approximately three years ago, your insight into the seriousness of your conduct remains limited. This was reflected in your submissions to the panel, in which you appeared to attribute responsibility for the incident to others rather than demonstrating full accountability for your actions.

The panel considered whether a Suspension Order would be sufficient to protect the public, uphold public confidence in the profession and maintain professional standards.

The panel took into account the lack of personal accountability and the limited insight you have demonstrated, together with the limited evidence of the training undertaken. The panel considered that there was insufficient evidence demonstrating how you would apply the learning gained from that training to your clinical practice. In the absence of such evidence, the panel was not satisfied that there was a realistic prospect of you addressing the concerns to a level that would enable you to return to practice safely.

Given the seriousness and nature of the facts proved, it determined that suspension would not provide sufficient protection or adequately address the wider public interest concerns. The panel determined that a Suspension Order would not be a sufficient, appropriate or proportionate sanction.

In considering a Striking-off Order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated:

28/01/2026). Under the sub-heading entitled "*Cases involving dishonesty*", it stated:

> *"… Generally, the forms of dishonesty which are most likely to require consideration of striking-off will involve (but are not limited to):*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
> - *…*
> - *personal financial gain from a breach of trust*
> - *direct risk to people receiving care*
> - *premeditated, systematic or longstanding deception*

The panel was satisfied that all of the above were engaged in this case. It also considered your dishonesty constituted a deliberate systematic approach in misleading employers and you deliberately breached the professional duty of candour. This demonstrated evidence of deep-seated attitudinal problems that pose a risk to both patient safety and public interest.

The panel also noted that breaching interim orders fell within the category of 'highest risk cases' under the sub-heading "*Cases Involving Deliberate Breach of an Interim Order*" which states:

> *"If a professional deliberately doesn't comply with an interim or final order this can demonstrate a risk to the public. It is likely to be an aggravating factor and call into question whether they should remain on the Register, because it shows a disregard for the protections the Committee put in place and undermines the likelihood they will comply with any other sanction."*

Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

Honesty is of central importance to a professional's practice because of the trust placed in them by the public. Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

In light of your lack of personal accountability, limited insight and the insufficient evidence of strengthened practice, the panel concluded that there was no realistic prospect of you addressing the concerns, either during or following any additional period of suspension, to the extent necessary to demonstrate that you could return to safe and unrestricted practice

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a Striking-off Order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, 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 protecting the public, maintaining public confidence in the profession, and sending the public and the profession a clear message about the standards of behaviour required of a registered nurse.

This will be confirmed to you 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 your own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Radley. Given the panel's findings in relation to sanction he submitted that only an interim suspension order for a period of 18 months will be appropriate. He also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

You did not make any submissions regarding this application.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

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

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

That concludes this determination.