Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 27 October 2025 – Friday, 31 October 2025
Thursday, 6 November 2025 – Friday, 7 November 2025
Wednesday, 26 November 2025
Monday, 26 January 2026 & Thursday, 29 January 2026

Virtual Hearing

Name of Registrant:	Joyce Shingai Bare
NMC PIN:	12C1155E
Part(s) of the register:	Registered Nurse Sub part 1 RNA: Adult nurse, level 1 (14 September 2012)
Relevant Location:	Leeds
Type of case:	Misconduct
Panel members:	Rachel Cook (Chair, Lay member) Colin Mark Allison (Lay member) Janet Fitzpatrick (Registrant member)
Legal Assessor:	Trevor Jones (27 October 2025 – 31 October 2025) Charles Conway (6 November 2025 – 7 November 2025, 26 November 2025, 26 January 2026 & 29 January 2026)
Hearings Coordinator:	Abigail Addai Samara Baboolal (26 November 2025)
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Ms Bare:	Present and represented by Chuba Nwokedi, instructed by the Royal College of Nursing (RCN)
No case to answer:	Rejected
Facts proved by admission:	Charges 1, 2, 4d(ii), 4e(i)

Facts proved:	Charges 4a, 4e(ii), 4e(iii), 4e(iv)
Facts not proved:	Charges 3, 4b, 4c, 4d(i), 5
Fitness to practise:	Impaired
Sanction:	**Conditions of Practice Order (9 months)**
Interim order:	**Interim Conditions of Practice Order (18 months)**

Details of charge (as amended)

That you, a registered nurse, whilst working at Leeds Teaching Hospital NHS Trust:

1) On 23 September 2022, administered Furosemide to Patient A at a rate of 24ml per hour instead of the prescribed rate of 2.08ml per hour;

2) On 21 February 2023, failed to administer Digoxin to Patient B;

3) On 24 April 2023, failed to administer Levetiracetam, an anti-seizure medication, to one or more patient at the prescribed time or alternatively in a timely manner without clinical justification:

4) Between 15 September 2023 and 16 September 2023 whilst working at Harrogate and District NHS Foundation Trust:

a) on one or more occasion, failed to administer prescribed pain relief to Patient C when requested, without clinical justification;

b) attempted to take observations for Patient C using force and/or without consent;

c) failed to administer Oxycodone to Patient C in a timely manner;

d) in relation to Patient C's request for further pain relief you:

i) failed to follow up with the duty doctor and/or seek advice from the nurse in charge;

ii) informed Patient C and/or their carer that you were awaiting a response from the duty doctor and/or nurse in charge;

e) failed to update, adequately or at all, Patient C's medical records, in that you:

i) did not document that Patient C had refused to have their observations taken;

ii) did not document that you had requested further pain relief for Patient C and/or had bleeped the duty doctor;

iii) did not document that you had administered codeine to Patient C;

iv) did not document the reason why you had not given Oxycodone to Patient C in a timely manner;

5) Your conduct at charge 4(d)(ii) was dishonest as you knew that you had not contacted the duty doctor and/or spoke to the nurse in charge.

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

Background

Case reference: 096962

On 10 October 2023, the NMC received a referral from TFS Healthcare Agency ("the Agency") following several medication errors made by you between February 2022 and April 2023, whilst working at the Leeds Teaching Hospital NHS Trust ("Leeds"). Witness 1 and Witness 2 gave evidence in relation to these medication errors.

Case reference: 097028

[PRIVATE]

Patient C was treated on 15 September 2023 and had undergone a procedure in theatre. During the night of 15 September into the morning of 16 September 2023, Patient C was supported by their father, and their carer. This was Patient C's first admission to [PRIVATE], as it was not their local hospital.

It is alleged that during a night shift, between 15 and 16 September 2023, you failed to listen to Patient C's repeated requests for pain relief, the request was made by others including Patient C's father and their carer. You allegedly said that you had contacted a doctor and were awaiting their advice before you were able to give Patient C pain relief. It is also alleged that you had not made attempts to contact the duty doctor as you had indicated. In addition, it is alleged that you used force to take Patient C's observations, despite them resisting and refusing to co-operate by telling you to '*get off them*'.

Following the complaint, Harrogate undertook a local investigation during which it was disclosed that you had only bleeped for the doctor once, and not twice as you had had alleged in your reflective account. This was despite assuring Patient C and their family that you were awaiting advice. It was understood that Patient C had been prescribed Oxycodone to be administered at 01:00, however, it is stated that you failed to do so. It is also said that you failed to escalate the issues related to Patient C's pain management to the nurse in charge, and failed to keep or complete accurate records during the shift, including your failure to document the administration of medication to Patient C.

Admissions

At the outset of the hearing, the panel heard from Mr Nwokedi, your representative, who informed the panel that you made full admissions to charges 1, 2, 4(d)ii, 4e)i

The panel therefore finds charges 1, 2, 4(d)ii, 4(e)i proved in their entirety, by way of your admissions.

Witnesses

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

- Witness 1: Clinical lead at TFS Healthcare Agency at the time of the concerns;
- Witness 2: Lead Nurse at the Leeds Teaching Hospital NHS Trust at the time of the concerns;
- Witness 3: GP Trainee at the Harrogate and District NHS Foundation Trust at the time of the concerns;
- Witness 4: Matron for Planned and Surgical Care at Harrogate District Hospital ("the Hospital") at the time of the concerns;
- Witness 5: Ward Sister on the [PRIVATE] at Harrogate District Hospital at the time of the concerns;
- Patient C: Inpatient on the [PRIVATE] at Harrogate District Hospital at the time of the concerns;

The witness statement of Witness 6 was accepted by the panel as agreed evidence. Witness 6 was a Senior Sister at [PRIVATE] at Leeds at the time of the concerns.

Decision and reasons on application for Witness 4's evidence to be held in private

During the course of Witness 4's evidence, Mr Nwokedi made a request that parts of Witness 4's evidence should be heard in private on the basis that proper exploration of Witness 4's evidence involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Edwards, on behalf of the Nursing and Midwifery Council (NMC), did not oppose the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to [PRIVATE] in Witness 4's evidence, the panel determined to hold those parts of the hearing in private in order to protect their privacy.

Decision and reasons on application for Patient C's evidence to be held in private

Mr Edwards and Mr Nwokedi made a joint application for Patient C's evidence to be heard entirely in private. They submitted that Patient C is a vulnerable witness, and as such, the entirety of their evidence should be heard in private on the basis that it would be easier for them to give the best evidence.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that Patient C is a vulnerable witness, the panel determined to hold the entirety of Patient C's evidence in private in order for Patient C to give their best evidence. The panel noted that Patient C is anonymised, but considered there to be potential for Patient C to be identified through the detailed reference to [PRIVATE].

Decision and reasons on application to amend the charge

Having heard all the evidence, following Mr Nwokedi's indication that he intended to make a submission of no case to answer, the panel of its own volition and under Rule 28, invited the advocates to make submissions regarding the wording of Charge 5. The panel was of the view that Charge 5 may not reflect the facts alleged in charge 4(d)ii, and as such, sought to seek clarity behind Charge 5's wording.

At present, Charge 5 reads as follows:

> 5) *Your conduct at charge 4(d)ii was dishonest as you knew that you had not contacted the duty doctor more than once and/or spoke to the nurse in charge to discuss Patient C's increasing pain levels and sought to mislead others into believing that you had.*

Mr Edwards submitted that in the absence of instructions, he would not be making an application to amend Charge 5, and it is a matter for the panel. He submitted with regards to the dishonesty, the NMC rely upon your reflective piece, where you state that you bleeped Witness 3 twice. Further, the phrase 'and/or' derives from Patient C's written and oral evidence, where they state that you informed them that you were going to speak to Witness 5 about their pain levels. However, Witness 5 states no concerns were raised to her. Mr Edwards submitted that the panel could find part of the charge proved, if it deems that there is sufficient evidence.

Mr Nwokedi submitted that your reflective piece did not state that you bleeped Witness 3, rather that you bleeped a doctor. He submitted that you state that you had bleeped twice, first to the wrong number, then to the right number later on. Mr Nwokedi further submitted that should the panel be of the view to amend Charge 5, it should do so before his

submissions of no case to answer in respect of charges 4a, 4b, 4c, 4d(i), 4e(ii), 4e(iii), 4e(iv) and 5.

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 having considered the wording of Charges 4d(ii) and 5, determined to amend Charge 5 to read as follows:

5) *Your conduct at charge 4(d)ii was dishonest as you knew that you had not contacted the duty doctor more than once and/or spoke to the nurse in charge*

The panel noted that Charge 5 states that "*Your conduct at charge 4d(ii) was dishonest*" but that Charge 5 also includes additional detail that is not within Charge 4d(ii). This additional detail includes the phrases '*more than once'* and '*to discuss Patient C's increasing pain levels and sought to mislead others into believing that you had*'. The panel considered it appropriate and fair for the wording of Charge 5 to align with the wording of Charge 4d(ii). The panel therefore amended Charge 5 accordingly.

The panel was of the view that such an amendment, was 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 amendment being allowed. It was therefore appropriate to amend charge 5, to ensure clarity and accuracy.

Decision and reasons on application of no case to answer

After the NMC closed its case, the panel considered an application from Mr Nwokedi that there is no case to answer in respect of charges 4a, 4b, 4c, 4d(i), 4e(ii), 4e(iii), 4e(iv) and 5. This application was made under Rule 24(7).

With regards to the alleged facts, including the alleged failure to administer pain relief and forceful observations, Mr Nwokedi submitted that Patient C's evidence is unreliable. He submitted that there are memory deficits, and their account contradicts other NMC

witnesses. Further, Mr Nwokedi indicated that Patient C's evidence is largely '*second hand'*, because Patient C said in oral evidence that they had put their NMC witness statement together with the help of others, which questions its true independence.

Mr Nwokedi submitted that further evidence points to the complaints being made by Patient C's mother, who at no point was called to give evidence or called to give a statement to the NMC. Mr Nwokedi was of the view that Patient C's mother's complaints were purely hearsay because Patient C's mother was not present on 15 and 16 September 2023. Mr Nwokedi also raised his concern that during Patient C's oral evidence, and despite Patient C being asked not to discuss the case with anyone, Patient C's mother asked if she could send an email to the panel regarding comments Patient C wished to make during the hearing.

Mr Nwokedi submitted that he understands that the panel will be of the view that Patient C has needs that should be accommodated. However, he submitted that the panel has before it an intermediary assessment, which highlighted the support required from an intermediary would assist Patient C. In light of this, Mr Nwokedi indicated that Patient C's evidence, taken at the highest level, cannot be relied upon.

Mr Nwokedi submitted the evidence from Witness 4 cannot be relied upon because she spoke to Patient C's mother, not Patient C's father and carer who were present at the time of the incidents. He submitted that the hearsay evidence cannot outweigh the contemporaneous clinical evidence and direct witnesses in respect of charge 4b. Further, the allegation originated from a complaint by Patient C's mother several weeks later, and the Datix report outlined that Patient C was not injured. Therefore, the evidence before the panel is incapable of proving force at its highest. [PRIVATE].

With regards to charge 4c, Mr Nwokedi informed the panel that you say you were advised not to administer the Oxycodone until 1:00, and by this time, Patient C was already asleep. Further, the panel heard from Witness 5 and Witness 3 who said it would be appropriate to defer medication until a patient is awake. He also submitted that there was

no evidence of complaints on the [PRIVATE] from Patient C's carer, who was with Patient C at the time of the incident.

With regards to charge 4d(i), Mr Nwokedi submitted that the panel has seen the bleep log, and Witness 5 has stated that she was aware that you called the relevant duty doctor. Moreover, Witness 3 gave you instructions and prescribed Oxycodone, which demonstrated that a follow-up did occur.

With regards to charge 4e(ii), 4e(iii) and 4e(iv), Mr Nwokedi submitted that any record gaps are minor administrative matters, which have been explored by the witnesses as 'common' amongst agency staff. Witness 5 confirmed the documentation for the night shift was adequate and not unsafe. Further, the Datix investigation raised no suggestion of concealment. As such, there is no evidence of harm arising.

In respect of charge 5, Mr Nwokedi submitted that the alleged dishonesty derives from charge 4(d)ii. He submitted that the panel have evidence that you bleeped the doctor and that the doctor prescribed Oxycodone. This is corroborated by Witness 5 and Witness 3, and your statement where you state that you were '*waiting for the doctor'*.

Mr Nwokedi submitted that while you have not given evidence yet, you would nevertheless say you initially bleeped the wrong number, then the right one after. Therefore, there is no evidence to mislead as required within the dishonesty test set out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67.

In conclusion, Mr Nwokedi submitted that the evidence fails to safely establish that you withheld or delayed pain relief. As such, the evidence fails to safely establish any non-consensual act, use of force or a failure to escalate, and provides no basis of a finding of dishonesty.

Mr Edwards opposed the application of a no case to answer in relation to the charges. He submitted that the panel has heard from Patient C who gave clear evidence of what happened on 15 and 16 September 2023.

Mr Edwards submitted that Patient C was clear in her evidence that despite repeated requests for pain medication, those requests were refused. He also referred the panel to Patient C's evidence, namely that you attempted to take observations despite her not liking to be touched and finding this unpleasant. Further, the panel have heard how this experience still affects her to this day.

Mr Edwards submitted that although the witnesses did not see anything, this does not mean that the incident did not occur as described by Patient C. He submitted that the evidence the panel have heard is not tenuous, and there is sufficient evidence to support these charges. Therefore, Mr Edwards invited the panel to find that there is a case to answer in respect of charges 4a, 4b, 4c, 4d(i), 4e(ii), 4e(iii), 4e(iv) and 5.

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

Charge 4a

The panel had regard to the Electronic Prescribing and Medicines Administration record (EPMA), in relation to Patient C dated 15 and 16 September 2023. It noted that a number of regular pain relief medications had been prescribed to Patient C on 15 September 2023, but are not recorded as being administered to Patient C. The panel also took into account Patient C's oral and written evidence, and the evidence from Witness 1 and Witness 4.

The panel therefore concluded that when taken at its highest, there is some evidence to support this charge and that this evidence is not tenuous. Accordingly, the panel found there is a case to answer.

Charge 4b

The panel took into account Patient C's witness statement which reads:

> *'J came over anyways to my left grabbing my arm trying to put it in the blood pressure cuff.'*

The panel noted that Patient C's account remained consistent in their local statement dated 5 November 2023 to the NMC, their witness statement dated 11 June 2024, and in their oral evidence.

The panel therefore concluded that when taken at its highest, there is some evidence to support this charge and that this evidence is not tenuous. Accordingly, the panel found there is a case to answer.

Charge 4c

The panel had regard to the EPMA record and noted that Oxycodone had been prescribed to Patient C. However, there was no evidence of it being administered to Patient C. According to the EPMA record, the panel noted that the oral Oxycodone was prescribed at 23:22 on 15 September 2023 but did not appear to be administered until 7:17 on 16 September 2023.

The panel therefore concluded that when taken at its highest, there is some evidence to support this charge and that this evidence is not tenuous. Accordingly, the panel found there is a case to answer.

Charge 4d(i)

The panel had regard to the witness statement of Witness 5 dated 8 May 2024, in particular paragraph 15 which reads:

> *'Neither Ms Bare nor Ms 1 escalated any concerns to me that Patient C had requested further pain relief medication, or that the patient was struggling with pain'*

The panel also considered Witness 5's oral evidence.

The panel therefore concluded that when taken at its highest, there is some evidence to support this charge and that this evidence is not tenuous. Accordingly, the panel found there is a case to answer.

Charge 4e(ii), Charge 4e(iii) and Charge 4e(iv)

The panel had sight of and took into account Patient C's end of shift report dated 16 September 2023 and Patient C's EPMA record. The panel noted that there was limited documenting within Patient C's medical records.

The panel therefore concluded that when taken at its highest, there is some evidence to support these charges and that this evidence is not tenuous. Accordingly, the panel found there is a case to answer.

Charge 5

The panel had regard to your reflective piece which states the following:

'I informed the sister in charge I worked with and bleeped the Dr to prescribe'

However, the panel found this contradicted paragraph 15 of Witness 5's witness statement as referred to above.

The panel therefore concluded that when taken at its highest, there is some evidence to support this charge and that this evidence is not tenuous. Accordingly, the panel found there is a case to answer.

Decision and reasons on facts

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

The panel also heard evidence from you under affirmation.

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

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

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

Charge 3

> 'On 24 April 2023, failed to administer Levetiracetam, an anti-seizure medication, to one or more patient at the prescribed time or alternatively in a timely manner without clinical justification:'

This charge is found NOT proved.

In reaching this decision, the panel had regard to the witness statement of Witness 1, which stated that the Day Staff did not administer the Levetiracetam medication to Patient D or to Patient E, and that you were required to give the medication at 20:00. Further, it noted from Witness 1's statement that Levetiracetam is *'a time critical medication and it must be given at a specific time'.*

The panel had regard to the incident complaint form that stated at 9:00 the following day, the day staff noted the medication had not been administered, and a Datix was produced. It was also alleged that one of the patients was suspected to have had a seizure, which Witness 1 stated, in her witness statement, was potentially caused because the medication was not administered for over 15 hours.

The panel took into account that Witness 1 is not a direct witness to the incident and was not present in the hospital at the time of the alleged incident.

The panel further had regard to Patient D's drug chart, in particular the section relating to the Levetiracetam tablet which stated, on 24 April 2023 at 17:50, that 500mg of the medication was withheld.

It also took into account Patient D's clinical notes which read:

> *'Thinks right leg more myoclonic than seizure activity. Agrees with above plan, fluctuating GCS in keeping with his admissions progression but agrees CT head to be certain. To monitor closely.'*

The panel noted the reference to 'myoclonic' which it considered was contrary to the view of Witness 1 that Patient D could have suffered a related seizure.

In relation to Patient E, the panel had regard to Patient E's drug chart and noted that the medication was recorded at 11:27 on 24 April 2023 but was noted as 'missed' on 25 April 2023.

The panel also considered Patient E's clinical notes, in particular, the section recorded by you on 25 April 2023 at 05:00:

> *'settled night… medication given as prescribed, tolerated well'*

The panel found no evidence that Patient E had suffered a seizure.

It also noted that the administration of the Levetiracetam had not been recorded in Patient D's and E's EPMA record. However, it had regard to your reflective piece dated 2 May 2023, which the panel regarded as contemporaneous because it was made only a few days after the incident. Your reflective piece states as follows:

‘When I was in the middle of medication administration I realised that the laptop I was using was not working properly, I switched over to the other trolley and continue with giving medication till the very last patient I was allocated to.’

The panel was of the view that your oral evidence was consistent on this point. You told the panel that, as a priority, you administered and recorded the Levetiracetam medication for Patient’s D and E. You said you then moved on to administering the medication for the next patient but the laptop ‘*froze*’ and so you used a different laptop.

Taking into account your relatively contemporaneous reflective statement, your consistent oral evidence and the absence of evidence that either Patient D or E suffered a seizure, the panel did not find that on the balance of probabilities that you failed to administer Levetiracetam to Patient D and E at the prescribed time, or alternatively in a timely manner without clinical justification.

Accordingly, the panel found charge 3 not proved.

Charge 4a

‘Between 15 September 2023 and 16 September 2023 whilst working at Harrogate and District NHS Foundation Trust: on one or more occasion, failed to administer prescribed pain relief to Patient C when requested, without clinical justification’

This charge is found proved.

In making this decision, the panel took into account that the witnesses for this incident were Patient C, Witness 3, and Witness 5. It noted that Witness 1’s evidence only speaks to the investigation around the incident, and Witness 4’s evidence derives from a conversation she had with Patient C’s mother, weeks after the incident.

The panel had regard to Patient C's evidence, namely that they had requested pain relief. They also said that their father and their carer had asked for pain relief on their behalf. The panel did not hear evidence from Patient C's father or Patient C's carer.

[PRIVATE]

The panel also took into account that the EPMA record was annotated with handwritten times and dates as to when a number of medications were prescribed. Witness 4 told the panel, in oral evidence, that she was the author of the handwritten annotations and that these were copied from other tabs in the online prescribing system, not provided in the evidence bundle. The panel noted that according to the EPMA record, the pain relief, as referred to above, was to be administered at the following days and times:

Codeine

15 September 2023 at 18:59. It was accepted by Patient C in their oral evidence and witness statement that you administered Codeine on the evening of 15 September 2023.

The panel also noted from the EPMA record that Codeine phosphate was 'ceased' on 15 September 2023, providing evidence that in any event this pain relief was not administered after 00:01 on 16 September 2023.

Liquid Oxycodone

This was prescribed by Witness 3 at 23:32 and the EPMA record stated that this was to be administered at 01:00. This is further supported by the handwritten annotation by Witness 4.

Paracetamol

This was prescribed at 18:09 on 15 September 2023. However, you did not appear to have administered Paracetamol to Patient C.

Naproxen

The Naproxen was prescribed on 15 September 2023 at 12:34, and the panel noted that within the EPMA record, this is documented under 15 September 2023 as 'withheld' at 19:01. The panel noted that Patient C was in theatre undergoing surgery between approximately 18:00 and 20:00 and concluded that the Naproxen medication may have been withheld because its administration coincided with Patient C's surgery.

The panel also noted that Naproxen was due to be administered only once more that day (at 22.00), after the dose received at 12:41 on 15 September 2023. However, you did not appear to have administered Naproxen to Patient C at 22:00. It is unclear why this third and final dose of the day was apparently not received by Patient C.

Oxycodone (tablet form)

The panel noted that according to the handwritten annotation of Witness 4, the Oxycodone (tablet form) had been prescribed on 15 September 2023 at 19:00. However, you did not appear to have administered Oxycodone (tablet form) to Patient C at 21:00 per the timings on the EPMA record.

Nefopam

The panel took into account that, according to the handwritten annotation of Witness 4, the Nefopam was prescribed for Patient C on 16 September 2023 at 17:01, and as such, was not available for you to administer on 15 September 2023.

You told the panel that you did not see the prescription for Naproxen or the Oxycodone tablet form on Patient C's EPMA chart during 15 to 16 September 2023. However, the

panel had regard to Witness 3's statement which stated that Witness 3 was bleeped by you at 23:14 and that Witness 3 checked the online chart. Witness 3 statement reads as follows:

> '…*I was only bleeped for this request at 23:14. I could see from the patient's online drug chart that the patient had paracetamol, naproxen, codeine phosphate, and oral oxycodone (modified release) already prescribed on the drug chart.'*

The panel understood oral oxycodone (modified release) to be Oxycodone tablet form.

The panel therefore concluded that the prescription of Oxycodone (tablet form) and Naproxen was prescribed and visible to you on the EPMA record. Despite your evidence that you did not see the drugs in Patient C's EPMA record, the panel noted that it was visible to Witness 3 who also checked the EPMA record on the evening of 15 September 2023. The panel therefore concluded that it was likely that you did see it.

The panel therefore concluded that the pain relief of Oxycodone (tablet form), Paracetamol, and Naproxen were prescribed for Patient C and were available for you, and you knew you had to administer it. Furthermore, the panel did not find any clinical justification as to why you with held this prescribed pain relief from Patient C.

Therefore, the panel found charge 4a proved.

Charge 4b

> 'Between 15 September 2023 and 16 September 2023 whilst working at Harrogate and District NHS Foundation Trust, attempted to take observations for Patient C using force and/or without consent'

This charge is found NOT proved.

In reaching this decision, the panel had regard to Patient C's local statement, dated 5 November 2023, in which they said:

> *'J* [You] *came over anyways to my left grabbing my arm trying to put it in the blood pressure cuff... Ms 1 stepped back in telling her she can't do that I told her no and to stop it which she did whilst again saying she needed it done for her shift'*

The panel was informed that this local statement was not made in the immediate aftermath of the alleged assault on 15 to 16 September 2023, but several weeks after the alleged assault on 5 November 2023. Further, the panel took into account Witness 4's statement and that Patient C did not raise the alleged assault herself, but it was raised by Patient C's mother '*in passing'* on 5 October 2023. Witness 4 described the conversation as '*unusual'*, stating the following:

> *'When half way through that conversation, Patient C's mother abruptly told me that on 15/16 September 2023, Ms Bare* [you] *had forcefully tried to take Patient C's blood pressure despite the patient resisting and telling them to stop…I couldn't understand why they did not mention it to me earlier given the severity of the allegation'*

The panel also noted that the alleged assault was reportedly overseen by Patient C's carer. However, the panel had no witness statement from the carer. It also noted that Patient C's carer knew a member of staff on the [PRIVATE]. This is supported by Witness 5's witness statement and oral evidence; '*the carer was talking to a colleague'*.

Witness 5, who was the nurse in charge of the shift also informed the panel in her oral evidence that no concerns were raised to her by you, Patient C nor the carer. Within her written statement, Witness 5 states as follows:

> '*On 16/17 September 2023, I also spoke to Ms 2 about their conversations with Ms 1 that night. Ms 2 is Polish like Ms 1, and the two had been conversing overnight. I*

know Ms 2 very well, and if Ms 1 had raised any concerns about Patient C or their care to Ms 2 ,then Ms 2 would have raised it to me immediately. Ms 2 also did not note any concerns or that Patient C was in pain during the night of 15/16 September 2023, and mentioned to me that Ms 1 was nice and that they had been having a general chat with them.'

Witness 5 confirmed this account in her oral evidence.

The panel also found Patient C to be clear in her local statement and oral evidence. It also found that you were equally as clear in your oral evidence. You told the panel that you always asked Patient C if you could take their observations. You also said that there was an occasion when Patient C refused, and you said Ms 1 encouraged Patient C to have their observations taken. You told the panel that your practice is that if there is no consent made, you withdraw. The panel found your evidence to be consistent with Patient C's observation chart dated 15 September 2023, noting that three observations had been taken by you on 15 and 16 September 2023 at 20:47, 00:01 and 00:49.

The panel also noted within Patient C's observation chart that Patient C had refused observations from other nurses on 16 September 2023 at 17:50, and 17 September 2023 at 19:45. It also took into account Patient C's oral evidence, when they told the panel that they do not normally have any difficulty having observations taken. However, it found this evidence to be in contrast to the observation sheet on 16 and 17 September 2023 as referred to above.

In light of the above, the panel preferred your evidence, noting some inconsistencies with Patient C's evidence and noted the significant delay in Patient C reporting the alleged assault.

In all the circumstances, the panel found charge 4b not proved.

Charge 4c

‘Between 15 September 2023 and 16 September 2023 whilst working at Harrogate and District NHS Foundation Trust, failed to administer Oxycodone to Patient C in a timely manner’

This charge is found NOT proved.

The panel noted that liquid oral Oxycodone was prescribed to Patient C by Witness 3 at 23:14. It heard from you that you did not administer the Oxycodone soon after 23:14, as Patient C was asleep. The panel heard from a number of witnesses, including Witness 4 and Witness 5, that it would not be best practice to wake a sleeping patient to administer pain relief medication. Further, the EPMA record shows that the liquid Oxycodone was due at 01:00 and administered at 7:17.

The panel concluded that the central issue was whether or not at the time when you were able to administer the prescribed liquid Oxycodone medication, from 01:00, because Patient C was asleep. The panel noted from Patient C’s oral evidence that they assert that they were not soundly asleep as Patient C was *‘crying, tossing and turning, getting a lot worse and was waking up and screaming.’* However, the panel had regard to Patient C’s mother’s email dated 24 October 2023:

‘Ms 1 reports that at around 3am, She and Patient C fell asleep / were dozing. She described as being in a 'fitful / unsettled sleep', explaining that she would go quiet, but then start whimpering and crying and then going back to sleep again’

The panel noted that there was no reference to Patient C screaming, rather there were references to Patient C falling asleep and ‘going back to sleep again.’ The panel therefore considered it conceivable that at the times you checked on Patient C, from 01:00 onwards when the prescribed liquid oral Oxycodone was due, Patient C could have appeared to you to be asleep.

The panel also took into account your reflective piece dated 5 October 2023 which reads:

> *'(Morphine) was prescribed for 1am, patient and the carer informed, and reassurance given and I continued checking the patient and by the time the medication was due to be given patient both the patient and the carer were fast asleep and could not disturb the patient since they appeared settled and comfortable.'*

Taking into account your reflective piece and Patient C's mother's email, the panel preferred your evidence and found charge 4c not proved.

Charge 4d(i)

> 'Between 15 September 2023 and 16 September 2023 whilst working at Harrogate and District NHS Foundation Trust, in relation to Patient C's request for further pain relief you, failed to follow up with the duty doctor and/or seek advice from the nurse in charge'

This charge is found NOT proved.

The panel decided to consider charge 4d(i) in two parts, whether you failed to follow up with the duty doctor and whether you failed to seek advice from the nurse in charge.

With regards to the first part of the charge, the panel was of the view that Witness 3 was clear in her oral evidence, and witness statement, that she was contacted by you through the bleep system. The panel also had sight of an email from the Harrogate Switch Board, dated 4 October 2023, with the subject entitled 'bleep log' which confirmed that there was a bleep by you at 23:14 on 15 September 2023.

Accordingly, the panel found charge 4d(i) not proved in relation to failing to follow up with the duty doctor.

With regards to the second part of the charge, that you failed to seek advice from the nurse in charge, the panel considered whether you had a duty to speak to the nurse in charge.

The panel was of the view that you did not have a duty to seek advice from the nurse in charge, in the first instance, and that you had discharged your duty by 'bleeping' the doctor. It determined that you appropriately escalated the matter and used your clinical judgment to best assist Patient C.

Nevertheless, and for completeness, the panel went on to consider whether you failed to seek advice from the nurse in charge.

The panel noted from Witness 5's statement that Witness 5 said that she did not have a conversation with you. However, in oral evidence, Witness 5 was asked if she had any conversation with you during the night shift on 15 to 16 September 2023. Witness 5 replied "*…when you are the nurse in charge, it is quite normal to not recall every conversation*." In light of the above, the panel concluded that Witness 5 could not recall whether or not she had a conversation with you during the relevant shift.

The panel contrasted this with your clear evidence to the panel that you spoke to Witness 5 about Patient C, whilst Witness 5 was on the [PRIVATE] tending to a patient and administering intravenous antibiotics.

The panel concluded that the NMC had failed to establish that you had a duty to seek advice from the nurse in charge, and additionally, the NMC had failed to prove that you did not speak to Witness 5 about Patient C during the course of the relevant night shift.

Accordingly, the panel found charge 4d(i) not proved.

Charge 4e(ii), 4e(iii) and 4e(iv)

‘Between 15 September 2023 and 16 September 2023 whilst working at Harrogate and District NHS Foundation Trust failed to update, adequately or at all, Patient C’s medical records, in that you:

ii) did not document that you had requested further pain relief for Patient C and/or had bleeped the duty doctor;

iii) did not document that you had administered codeine to Patient C;

iv) did not document the reason why you had not given Oxycodone to Patient C in a timely manner’

This charge is found proved

The panel had regard to Patient C’s end of shift report which was completed on 16 September 2023. It noted that the report contained limited information about Patient C. There is no reference to you requesting further pain relief for Patient C, bleeping the duty doctor, administering pain relief, or the reason why you had not given liquid Oxycodone to Patient C in a timely manner.

The panel also had regard to Patient C’s EPMA record dated 15 through 18 September 2023, and noted that, in relation to Codeine, it is blank under the entry for 15 September 2023. Although you and Patient C confirm that Codeine was administered, the panel found no record of this within the EPMA.

The panel noted that in your oral evidence you said you completed the end of shift report appropriately, within the section entitled ‘clinical comments.’ You explained the systems between Harrogate and Leeds were different and it was appropriate in Harrogate to record the end of shift comments within the ‘clinical comments’ section. However, the panel did not have sight of the ‘clinical comments’ section and noted Witness 4’s clear evidence that the documentation was not completed properly. The panel noted that Witness 4 had investigated the allegations.

The panel did note that Witness 5 stated '*The EOS report was not very detailed regarding the patients care or noting any concerns, but was in my view adequate'.* However, Witness 4 said the following in her witness statement:

> *[PRIVATE]*

The panel also had sight of a 'crib sheet' relating to the end of shift report which clearly states the following:

> *'Clinical updates are to document any information between completing the 'Nursing End of Shift Report' not to replace it and should only be done in exceptional circumstances.'*

The panel therefore concluded that it was clear to you from the crib sheet that you should not have recorded the end of shift report within the clinical updates.

In relation to charge 4e(iv), the panel noted that charge 4c was not proven (failed to administer in a timely manner). However, it nevertheless considered that it was incumbent upon you to document the reasons for the non-administration of the liquid Oxycodone prescribed at 23.32 on 15 September 2023.

Taking into account the end of shift report, the evidence of Witness 5, the EPMA record, the evidence of Witness 4 and the relevant 'crib sheet', and having balanced all the information before it, found charge 4e(ii), 4e(iii) and 4e(iv) proved.

Charge 5

> 'Your conduct at charge 4(d)(ii) was dishonest as you knew that you had not contacted the duty doctor and/or spoke to the nurse in charge.'

This charge is found NOT proved.

In reaching this decision, the panel first had regard to *Ivey v Genting Casinos*, paragraph 74:

> '*When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest.'*

The panel also took into account that you admitted charge 4d(ii).

It also had regard to its decision relating to charge 4d(i), that you followed up the request with the duty doctor and did not have a duty to seek advice from the nurse in charge.

The panel then went on to consider your state of mind during the incident in question.

The panel accepted your evidence that you did speak to both Witness 5 and Witness 3. Moreover, Witness 3, in her evidence, was clear that you did contact her through the 'bleep' system.

Although Witness 5 did not recall you contacting her, she told the panel that *'when you are the nurse in charge, it is quite normal to not recall every conversation.'*

Therefore, the panel found that the NMC had failed to prove that you did not speak to Witness 5 about Patient C during the course of the relevant night shift.

Accordingly, the panel found that the NMC has not discharged its burden in establishing whether your conduct in charge 4d(ii), was dishonest and found charge 5 not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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 kindly, safely and professionally.

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

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

Submissions on misconduct

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

Mr Edwards invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Mr Edwards identified the specific, relevant standards where your actions amounted to misconduct, including 1, 1.1, 1.2, 1.4, 2, 2.1, 2.2, 2.3, 2.4, 2.6, 3, 3.1, 3.3, 3.4, 8, 8.1, 8.2, 8.3, 8.5, 8.6, 10, 10.1, 10.2, 10.3, 18, 18.1, 18.2, 19, 19.1, 20, and 20.1.

Mr Edwards submitted that your actions fell far below the standards expected of a registered nurse and all the facts amount to misconduct.

Mr Nwokedi submitted that you have not accepted that you fell so far short of your obligations that it amounts to misconduct. He then referred to the NMC Guidance: *Misconduct* (reference: Ftp-2a) and the relevant authority of *Dr Schodlock v General Medical Council (GMC*)[2015] EWCA Civ 769.

FTP-2A states:

> *'one-off clinical incidents won't usually require regulatory action if there is evidence that the professional has reflected and learned from their mistake and we consider that the risk of repetition is low.'*

Schodlock states*:*

> *'it was held that non-serious misconduct findings should not (in the case before the court) be rolled up to become a justification for a finding of current impaired fitness to practise.'*

Mr Nwokedi submitted that you accept that the proved matters engage core professional expectations.

With regards to charge 1, Mr Nwokedi submitted that this is a medication error and it was identified, escalated and there was no finding of actual harm. Further, there was no finding of recklessness or concealment. He submitted that the NMC guidance is explicit that one-off incidents where learning follows does not amount to misconduct.

Mr Nwokedi accepted that you could have taken more care with regards to the administration. However, this is not a case where it was serious as to amount to misconduct as it was not deliberate. He submitted the same can be said with regards to charge 2, as the error arose in the context of workload pressures and was not a deliberate disregard for patient safety. As such, your conduct in charge 2 is not so far short that it should amount to misconduct.

With regards to charge 4a and failing to administer prescribed pain relief to Patient C, Mr Nwokedi stated that you accept the panel's judgement. However, you submit that this was not intentional. Mr Nwokedi informed the panel that you were not being punitive by withholding the medication or disregarding the patient's needs. He submitted that pain management, while important, is clinically nuanced and the incident was a misunderstanding.

With regards to charge 4e and the failure to update medical records, Mr Nwokedi submitted that it is not an issue of dangerous practice or reckless harm towards the patient. Rather, these are administrative issues that can be addressed and are remediable. You accept your shortcomings with regards to the documentation. As such, it does not fall so far short as to amount to misconduct.

Submissions on impairment

Mr Edwards 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) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Edwards submitted that the case of *Grant* is engaged in this situation. He then referred the panel to *Cohen* in which it was stated that:

> *'... It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated.'*

Mr Edwards submitted that the conduct is easily remediable but the conduct has not been remedied. Therefore, there is a risk of repetition.

Mr Edwards submitted that the NMC invites the panel to find that your fitness to practise is impaired as of today's date. He submitted that while there is a reflective piece and recent training, the reflective piece does not adequately address the concerns raised in the charges. Further, Mr Edwards submitted that your reflective piece shows developing insight but does not show sufficient insight for the panel to be of the view that your conduct will not be repeated.

Mr Edwards submitted that it is commendable that you show some degree of insight in your reflective piece. However, he invited the panel to find that your fitness to practise is impaired on both public protection and public interest grounds.

Mr Nwokedi referred the panel to the authority of *PSA v NMC* [2017] CSIH 29 which confirms that a finding of misconduct would be the only correct outcome in this situation. He invited the panel to consider that you are not a danger to the public.

With regards to the case of *Grant*, Mr Nwokedi submitted that you have always acted honestly and accepted your failing with regards to allegations 1, 2 4d(ii) and 4e(i). He

submitted that you have been truthful, have not tried to hide from your responsibilities and have taken accountability.

Mr Nwokedi submitted that the allegations found proved do not seem to be evidence of deep seated attitudinal issues, and the misconduct in this case can and has been remedied. He referred the panel to your reflection where you outlined the impact of your actions and highlighted steps to make sure the likelihood of repetition is low. You also stated that you have read journals as a way of keeping your nursing skills up-to-date. Mr Nwokedi then referred to what you have submitted to address the concerns, including a Continued Professional Development (CPD) document dated 4 October 2023 (completed after the dates of the allegations) which addresses medicines management and administration.

With regards to Charge 2, Mr Nwokedi submitted that your reflection is clinically relevant. You identify and attribute the concern to poor communication and system issues. You then set out what steps you would take to improve. He submitted that with regards to charge 4a, you have read through the panel's decision and accepted the judgment of the panel. Therefore, this is a case where you have been able to demonstrate insight and highlighted steps to ensure that this will not happen again.

With regards to charge 4e and its subsections, Mr Nwokedi submitted that these are broader documentation failures and record-keeping communication issues. He submitted that this is not dishonesty and is capable of being strengthened.

Mr Nwokedi also referred to a training certificate dated 9 October 2025 covering essential IT skills which shows that you have addressed the IT issues.

Mr Nwokedi invited the panel that if it should find misconduct proved, then he respectfully invited the panel to find no current impairment.

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

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel was of the view that some of your actions fell 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:

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues.

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete all 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.

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.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered whether charges 1, 2, 4a, 4d(ii), 4e(i), 4e(ii), 4e(iii) and 4e(iv) amounted to misconduct.

Charge 1

The panel took into account Witness 1's witness statement which confirms that following the incorrect administration of Furosemide to Patient E, you admitted the error and completed a reflective statement. Witness 1 goes on to state the practice in such a situation:

'Following the completion of the reflective statement, a member from the Agency usually has a telephone call with the nurse to discuss the incident and next steps… The Agency did not have any concerns in regards to the reflection provided by Ms Bare.'

Annually, a mandatory training is provided to all the Agency nurses to ensure that they are aware of the requirements of medication administration practice. If a medication error is made, we enrol our nurses onto refresher training on medication administration'

The panel also had regard to your reflective piece dated 24 October 2023 in which you made admissions. You state that you believe that you made the medication error as a result of being very tired and the shift being on a '*very busy and hectic night*'.

The panel noted that Witness 1 was the clinical lead and is therefore likely to have been an experienced practitioner. It noted the use of Witness 1's language, namely the words 'usually' and 'what is normal' practice in such incidents. The panel considered that this wording suggested there was an established pathway for addressing administration of medication errors. The panel took into account that the Agency had no concerns as a result of you admitting the error, reflecting upon it and the subsequent medication administration training.

In light of Witness 1's approach, the panel considered that the error on this one occasion did not amount to serious misconduct.
Accordingly, the panel found charge 1 was not sufficiently serious or sufficiently below the standards expected of a nurse to amount to misconduct.

Charge 2

The panel first took into account Witness 1's witness statement which reads:

> *'Ms Bare was expected to give digoxin if heart rate was over 100 beats per minute as it was (noted by the doctor).'*

The panel also noted that you appear to accept this within your reflective piece:

> *'The Dr on duty asked me to do an ECG , to give IV furosemide, IV digoxin verbally and I asked her if she could prescribe it on system so I could give.[sic]*
> *When I checked on ppm IV furosemide was prescribed and I administered it. Digoxin was still the dose that was prescribed around 1600hrs and I did not give it. Patient continued to be monitored hourly as recorded on PPM. The Dr asked me to do the repeat ECG in the morning and I did but could not upload it on system. On arrival to the [PRIVATE] to check the ECG that's when she asked me why I didn't give digoxin and my reason was because it was not re-prescribed on the system'*

The panel had sight of the heart rate recordings for Patient B dated 21 February 2023 which confirmed that Patient B's heart rate exceeded 100. The panel also had regard to the EPMA and noted the 'STAT' prescription of Digoxin. The panel understood the word 'STAT' to mean the Digoxin should have been given immediately once it was established that the Patient's heart rate exceeded over 100.

Whilst the panel accepts that the EPMA records refer to the medication needing to be administered once, it took into account the evidence of Witness 1, the STAT being recorded on the EPMA and your evidence that the doctor asked you to do an ECG and to administer Furosemide and Digoxin.
The panel also considered the following from Witness 1's witness statement regarding the seriousness of not administering Digoxin:

> *'If the heart rate was fast and it was not treated, it may have led to a more sinister cardiac arrhythmia which ultimately could have caused cardiac arrest if left untreated. The digoxin was prescribed to treat the fast heart rate and to regain control of the heart to aim to avoid more serious cardiac rhythms developing.'*

Accordingly, the panel found charge 2 to be sufficiently serious and sufficiently below the standards expected of a nurse and amounted to misconduct.

Charge 4a

The panel took into account its finding on facts and noted that at the relevant time, Patient C had the potential to be administered the following:

- Paracetamol
- Naproxen
- Oxycodone tablet form

The panel noted that the pain relief of Oxycodone (tablet form), Paracetamol, and Naproxen were prescribed for Patient C and were available for you, and you knew you had to administer them. Furthermore, the panel did not find any clinical justification as to why you withheld these three different types of pain relief from Patient C.

The panel also determined that you were aware that Patient C was in pain because you had bleeped the doctor to seek advice regarding what pain relief you should administer. The panel considered pain management to be a fundamental part of a nurse's role.

Therefore, the panel determined that your actions were serious and did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 4d(ii)

The panel considered the wording of the charge 4d(ii):

4) Between 15 September 2023 and 16 September 2023 whilst working at Harrogate and District NHS Foundation Trust:

d) in relation to Patient C's request for further pain relief you:

ii) informed Patient C and/or their carer that you were awaiting a response from the duty doctor and/or the nurse in charge;

The panel considered that you did inform Patient C and/or their carer that you were awaiting a response from the duty doctor and/or the nurse in charge, but that the meaning of the wording of the charge does not amount to serious misconduct.

Charges 4e(i), 4e(ii), 4e(iii), 4e(iv)

The panel decided to consider the entirety of the charges in 4e together.

The panel noted that there were two differing opinions regarding your documentation:

Witness 5 stated '*The EOS report was not very detailed regarding the patients care or noting any concerns, but was in my view adequate'.* However, Witness 4 said the following in her witness statement:

[PRIVATE]

The panel took into account that you had various opportunities to accurately record what had taken place, including in the end of shift report and in relation to charge 4e(iii), Patient C's EPMA record. It considered that record keeping is a fundamental requirement of the nursing profession because a failure to update records could detrimentally impact the level of care a patient receives.

Therefore, the panel determined that your actions were serious and amounted to misconduct because Patient C was vulnerable at the time. Patient C recently had a surgical procedure which would have meant that contemporaneous documentation was vital for others caring for them.

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: 03/03/2025) in which the following is stated:

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. 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) ...'

The panel first had regard to your reflective piece dated 24 October 2023 in relation to charge 1 which reads:

'As soon as I received the message on my email, I called my clinical manager so I could have a clear picture of what happened
Understanding the pressure of working understaffed had made me administer the medication despite being tired as a way helping and lessening pressure on day staff. Unfortunately, it ended up as an error I was booked in the same [PRIVATE] on 23/09/23 and the patient was not discharged, I went to the patient and apologised for the error I had made in the morning and the patient was ok with me looking after her throughout the night

When administering a medicine, I will ensure I have an overall understanding of the medicine being administered and seek advice if necessary from a prescriber or a pharmacist.
Prioritisation of patients
I will make sure critical patients are my priority by make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, addressed and responded to with immediate effect My communication with other healthcare professionals should be clear, timely and discrete (NMC code of conduct on communication). Effective communication is needed to make accurate diagnoses, ensure that treatments are appropriately provided. [sic]'

The panel noted that your reflective piece outlines what you would do differently and that you extended your apologies to the patient for the drug error. Having demonstrated that you have insight into your failings in respect of charge 1, the panel went on to consider if this was featured within the charges on which misconduct was found.

In regard to charge 2, the panel noted your developed insight in relation to the context of the event, but you did not evidence sufficient insight into your own admitted failings.

Similarly, with regards to charges 4a, 4e(i),4e(ii), 4e(iii), 4e(iv), the panel determined that you have not evidenced sufficient insight. In reaching this decision, the panel took into account the following in your reflective statement:

> *'Appropriate staffing plays an important part in the delivery of safe and effective health and care. Safe staffing must be matched to patients' needs and is about skill-mix as well as numbers, about other staff as well as nurses, and other settings as well as hospitals.'*

With regards to your reflective piece, the panel was of the view that you did not adequately explain how your actions had impacted Patient C. It noted that you sought to blame external factors, including staff levels to ensure patient needs are met. However, there is limited reflections within your written reflection as to what you would have done differently if faced with a similar situation. As such, the panel determined that your insight is limited and that you are still liable to put patients at risk of harm.

With regards to your record-keeping, the panel had regard to the following within your reflective piece:

> *'I am dedicated to maintaining impeccable records'*

The panel was concerned that statement is an assertion of behaviour rather than a demonstration that you knew your record keeping fell below the required standards, you

knew why this had happened and that you had a plan in place to ensure that it would not happen again.

The panel noted that you had completed ‘medicines management and administration training’ on 15 March 2023 and this had included medication administration records, prescribing practices and types and reasons for errors. This training was valid for one year and covered the period during which the events of night of 15 September 2023 took place. The panel therefore questioned how effective the March 2023 training was for you.

The panel also noted you had undertaken comprehensive CPD of 31 hours in October 2023 which the panel found to be commendable. However, the panel was of the view that this training touches on only some of the concerns, namely medicines administration and does not address pain relief nor record keeping. As a result, the evidence before the panel does not sufficiently address how you are dedicated to maintaining impeccable records.

The panel then considered whether any of the limbs of the case of *Grant* are engaged. It concluded that failing to administer medication and failing to keep adequate medical records is liable to put a patient at unwarranted risk of harm. It further concluded that putting patients at unwarranted risk of harm and failing to keep adequate medical records, is liable to put the profession into disrepute and breaches fundamental tenets of the nursing profession. The panel accepted that limb d of the case of *Grant* was not engaged in this case.

The panel also had regard to the positive testimonial you provided. However, the panel noted that the testimonial speaks to your character, not your clinical practice. Therefore, the reference has not sufficiently alleviated the concerns raised.

The panel next took into account your evidence under affirmation where you state that you are currently a cleaner and have not worked as a nurse since 2024. In the absence of any evidence of strengthened practice, the panel concluded that the concerns have not been sufficiently addressed.

The panel then considered the questions posed in *Cohen* and concluded that your conduct is easily remediable, but was of the view that it has not been remedied and therefore it cannot be said that it is highly unlikely to be repeated.

The panel noted that at this stage your insight is developing but the concerns have not been sufficiently addressed through sufficient insight and remediation. In light of this, the panel determined that a risk of repetition remains.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required because members of the public would be shocked to find that a nurse, failed to administer medication which could have resulted in a cardiac arrest, withheld pain relief from a patient in pain and failed to update medical records.

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 carefully and has decided to make a conditions of practice order for a period of nine months. The effect of this order is that your name on the

NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Mr Edwards informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a suspension order for a period of six months if it found your fitness to practise currently impaired.

Mr Edwards submitted that the following aggravating features are present:

- The case concerns vulnerable patients, in particular Patient C.
- Patients were put at risk of harm as a result of your actions.
- A pattern of repeated misconduct.
- Lack of insight and understanding into your failings.

Mr Edwards submitted that the following mitigating feature is present:

- No further concerns have been raised in relation to your practice since the incident.

Mr Edwards submitted that these are serious charges and raises serious questions about your suitability to remain on the register. However, should the panel agree with the NMC's sanction bid, it should only be for a temporary period to mark the seriousness of the charges and adequately protect the public and serve the wider public interest.

Mr Nwokedi submitted that the risk identified by the panel is clinical and remediable. He submitted that the following mitigating features are present:

- No dishonesty or integrity concerns
- Your engagement in these proceedings
- Your developing insight which points to remediation

As a result, this removes the category of risk associated with a suspension or a striking-off order.

Mr Nwokedi informed the panel that you have been subject to an interim conditions of practice order and have fully complied with those conditions. He submitted that it has been highlighted that you have not worked as a nurse since 2024. However, you said that potential employers are waiting for the outcome of these proceedings before they will consider you for employment.

[PRIVATE].

Mr Nwokedi submitted that the clinical concerns that have been raised are capable of assessment, retraining and supervision. In these circumstances, Mr Nwokedi invited the panel to impose a conditions of practice order because there is no evidence of deep-seated attitudinal problems and there is a realistic prospect of remediation. He submitted that the conditions can be monitored and enforced to address the risk identified.

Mr Nwokedi submitted that if the panel considers it necessary, the conditions could include targeted training on pain management and record keeping. He submitted that a suspension order would be inappropriate because the risk is manageable and would delay remediation. However, should the panel choose to impose a suspension order, it should be for a period shorter than six months.

Mr Nwokedi also told the panel that after you were informed of the NMC's investigation, you were told to continue working. You subsequently worked for Exemplar Healthcare from October 2023 until February 2024 working with vulnerable children as a registered nurse. No further complaints were raised about your practice in that period.

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 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 Sanctions Guidance (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:

- The vulnerability of Patient C
- Limited insight into your failings

The panel did not accept that your actions amounted to a pattern of misconduct, rather that they arose from incidents on 21 February 2023 and 15 and 16 September 2023.

The panel further took into account Mr Nwokedi's submission that you worked with Exemplar Healthcare from October 2023 until February 2024. It noted that you worked with vulnerable children as a registered nurse with no concerns raised about your practice.

The panel took into account the following mitigating features:

- Two incidents in an otherwise unblemished career of 12 years (2012-2024).
- You have shown capacity to apologise to a patient in relation to charge 1 (although misconduct was not found).
- Early admissions to some of the charges.
- You have undertaken training courses.
- [PRIVATE].

The panel also considered whether you had support during your employment in Leeds and had regard to the following of Witness 1's witness statement:

'Ms Bare states that the staffing must be matched to the patients' needs. I believe this may be accurate as I received similar feedback from other Agency nurses working at Leeds. At times, there was one nurse and one HCA caring for over 15 patients and I agree that Leeds needed a greater staffing level'

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*

- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that other than the charges found proven relating to conduct in February 2023 and September 2023, you have had an unblemished career of 12 years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case because you have demonstrated developing insight. The panel further determined that whilst serious, the charges found proved were not at the most serious end of the spectrum, and that there is no risk to the public if you are allowed to continue practising as a conditions of practice order is an appropriate safeguard.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must ensure that you are working at all times on the same shift as, but not always directly observed by a registered nurse.

2. You must administer medication in the presence of another registered nurse until you have completed:

    a) Medication administration training
    b) Medication administration competence

3. You must have fortnightly meetings with your workplace supervisor to monitor your record keeping until you are signed off as competent.

4. You must send your case officer evidence that you have successfully completed medicines administration and record keeping training.

5. You must keep a reflective practice profile. The profile will:

    a) Detail a sample of your cases (minimum of six) where you administer medication and make an adequate record.
    b) Be signed by your workplace supervisor each time.
    c) Contain feedback from your workplace supervisor.

6. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.

b) Giving your case officer your employer's contact details.

7. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).

8. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for nine months. The panel considered nine months to be an appropriate period because it was of the view that you have demonstrated some insight and that remediation of your medication administration and record keeping could be successfully achieved within this period. The panel considered that restricting your practice by a nine month conditions of practice order was a sufficient and proportionate length of time to satisfy the public interest.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

A future panel reviewing this case would be assisted by:

- An up-to-date reflective piece addressing this panel's concerns, showing sufficient insight and how you can practise kindly, safely and professionally.
- References from any work you have undertaken in a healthcare or non-healthcare role (including voluntary roles).
- Any training undertaken since January 2026.

This will be confirmed to you in writing.

Interim order

As the conditions of practice 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 conditions of practice 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 Mr Edwards. He invited the panel to impose an interim conditions of practice order on the grounds of public protection and is otherwise in the public interest. Mr Edwards invited this panel to impose the interim order in the same terms as the substantive order for a period of 18 months to cover the appeal period.

Mr Nwokedi did not impose the application.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover the appeal period, and the time it may take to reach the Court should an appeal be lodged.

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

That concludes this determination.