Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 5 January 2026 – Thursday, 29 January 2026

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

Name of Registrant:	**Blessing Onyinyechi Igwe**
NMC PIN:	22F0421O
Part(s) of the register:	Registered Nurse – (Sub Part 1) Adult Nurse, Level 1 - 10 June 2022
Relevant Location:	Norfolk
Type of case:	Misconduct
Panel members:	Graham Gardner (Chair, lay member) Jason Flannigan-Salmon (Registrant member) Tracy Jones (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Ekaette Uwa
Nursing and Midwifery Council:	Represented by Vida Simpeh, Case Presenter
Ms Igwe:	Present and represented by Afzal Zami Syed-Ali, (instructed by the RCN)
Facts proved by admission:	Charges 3a), 3b), 4aii), 5a),5b), 5c), 5d), 6bi), 6c), 7a), 7b), 8a), 8b), 12a), and 17c), 19aii,19b)
Facts proved:	1a), 1bi), 1bii), 1c), 2a), 2b), 3c), 4ai), 4b), 6a), 6bii), 10), 11a), 11b), 12b), 12c), 12d), 13), 14a), 14b), 15a), 15b), 15c), 16), 17a), 17b), 17c), 18), 19ai)
Facts not proved:	2c), and 9)
Fitness to practise:	Impaired

Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Simpeh, on behalf of the NMC, to amend the wording of charge 12b).

The proposed amendment was to include the phrase '*prepared to be'* at the beginning of the charge. Ms Simpeh submitted that the amendment does not materially change the scope of the charge or widen it. She submitted that the proposed amendment would ensure that the charge is properly particularised and reflects the evidence.

"That you, a registered nurse:

12) On 21 October 2022:

a) …

b) **Prepared to be** administered Olanzapine to Patient E crushed rather than orally.

c) …

d) …

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

Mr Syed-Ali on your behalf, submitted that you are neutral to the application, but reserved the right to take instructions on your plea to the amended charge.

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 an amendment, as applied for, 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 allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Simpeh under Rule 31 to admit hearsay materials including:

- An email from Colleague C contained in exhibit YD/05; and
- An account recorded by Witness 3 on pages 210 and 211 of exhibit YD/04.

Ms Simpeh submitted that the evidence relates directly to Charges 1b) and 1c) and set out the complaint received from Witness 11, concerning the incident underpinning those charges.

Ms Simpeh referred the panel to the principles set out in *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). She submitted that the evidence is not sole and decisive and informed the panel that both Witness 11 and Witness 3 will be available for cross-examination, providing a direct means of testing its reliability.

Ms Simpeh submitted that there is no evidence to suggest that Colleague C or Witness 3 fabricated an account attributed to Witness 11. She submitted that although Colleague C has not provided a witness statement, her email is a contemporaneous summary of the conversation involving Witness 3, Witness 11 and herself.

Ms Simpeh therefore urged the panel to admit the relevant portions of the exhibits into evidence.

Mr Syed-Ali submitted that you oppose this application. He submitted that both Witness 3 and Witness 11 are scheduled to give evidence and Colleague C could have been called to give evidence regarding the hearsay material. He submitted that admitting these materials into evidence only serves the purpose of unfairly amplifying

any stream of evidence that will be given by the witnesses and thereby be procedurally unfair to you.

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

The panel first considered whether the evidence was relevant. It was of the view that both documents were relevant to the case.

The panel went on to consider its fairness to you. It noted that the hearsay evidence is not the sole decisive evidence in support of the charges. It observed that both Witness 3 and Witness 11 would be attending the hearing to give evidence and will therefore be available for cross-examination on the matters recorded in the email and the contemporaneous account. The panel considered that as the witnesses were available to give direct oral evidence, the admission of the documents would add little probative value.

The panel took into account that Colleague C, the author of the email, will not be attending to give evidence and therefore cannot be questioned about its content and context. It was of the view that this increased the risk of unfairness to you.

The panel determined that the interests of fairness outweighed the relevance of the evidence. The panel was satisfied that the factual issues can be fully and fairly explored through the live evidence of witness 3 and Witness 11, without the need to admit the hearsay materials.

In these circumstances the panel refused the application.

Details of charge (as amended)

That you, a registered nurse:

1) On 24 April 2022:

   a) Used a hoist sling incorrectly while transferring Patient A.

   b) Attempted to move Patient B contrary to her care plan in that you:

      i) Did not have the assistance of a second member of staff.
      ii) Did not use a ross return.
      iii) Pulled Patient B by her arm

   c) Told Patient B ‘you lazy, get up’ or words to that effect.

2) On 25 April 2022:

   a) Moved Patient B contrary to her care plan in that you did not have the assistance of a second member of staff.

   b) Told Patient C to use their incontinence pad rather than assisting Patient C to use the toilet.

   c) While responding to a safety alarm, pulled Patient K by her arm.

3) During a night shift on the 4 and 5 May 2022:

a) Slept whilst on duty.

b) Did not complete patient ~~international~~ **intentional** rounding care documents and/or handover documents.

c) Left Patient L in a wet bed after answering the patient bell.

4) Did not communicate effectively with Patient A during therapeutic wash and dress sessions in that you:

a) On 13 May 2022:

i) Stated ‘If you ask Patient A she will tell you the wrong thing’ or words to that effect.

ii) Stated ‘This will take ages’ or words to that effect.

b) On 9 August 2022 laughed at Patient A.

5) On 18 May 2022:

a) Required prompting to administer medication via a PEG tube at a slower rate.

b) Left the drug trolley keys out on the trolley.

c) Did not wash your hands when required.

d) Did not introduce yourself to patients before administering medications.

6) On 22 May 2022 in relation to Patient D:

a) After being told by Person A that Patient D needed the toilet, you poked Patient D’s crotch and said words to the effect of ‘you have a pad on for that’.

b) Moved Patient D contrary to his care plan in that you:

i) Did not have the assistance of a second member of staff.

ii) Pulled Patient D’s right arm.

c) Started pulling Patient D’s trousers and pants down when the window blinds and door to his room were open.

7) Provided Patient M unthickened drinks on:

a) 7 June 2022.

b) 9 June 2022.

8) On 30 June 2022:

a) Failed to wear personal protective equipment ('PPE') whilst in an enteric patient's room.

b) Left Patient N, with a hot drink without a lid when Patient N required supervision while eating and drinking,

9) On an unknown date in August 2022, in respect of Patient O, attempted to reinsert a used catheter which had become unsterile.

10) On 26 August 2022 left Patient P in a wet bed.

11) On an unknown date between 4 April 2022 and 19 December 2022:

a) Having been told by Patient F that he did not want to be fed anymore, pushed the spoon into Patient F's mouth.

b) Attempted to force feed Patient I.

12) On 21 October 2022:

a) Did not confirm the identity of one of more patients listed in Schedule 1 before administering medication to them.
b) **Prepared to be** administered Olanzapine to Patient E crushed rather than orally.
c) Administered water and medication via an enteral tube to Patient J too quickly.
d) Continued to feed Patient R via an enteral tube after laying the patient flat in bed.

13) On or around 24 October 2022 did not wear sterile gloves whilst changing Patient S's dressing.

14) On 25 October 2022 failed to follow Patient D's care plan in that you:

    a) Did not sit Patient D fully upright.

    b) Attempted to stand Patient D up without the assistance of a second member of staff.

15) On 9 November 2022:

    a) Required prompting to administer medication to Patient T.

    b) Did not wear gloves to administer a Dalteparin injection to Patient U.

    c) Required prompting to sign Patient V's drug chart after administering their medication.

16) On 30 November 2022 incorrectly told Colleague A that Patient W did not require 1:1 care.

17) On 13 December 2022 in relation to Patient G:

    a) Failed to follow the patient's manual handing care plan in that you attempted to transfer Patient G without the assistance of a second member of staff.

    b) Told Colleague B that another member of staff had assisted you to transfer the patient when they had not.

    c) Failed to complete a post fall care plan and/or Datix.

18) Your actions in charge 17 b) were dishonest in that you sought to create the impression you had transferred Patient G in line with their movement and handling care plan, when you knew you had not.

19) On 21 February 2023:

a) Failed to follow Patient H's care plan in that you:

i) Transferred Patient H without the assistance of a second member of staff.

ii) Transferred Patient H from the bed to the bathroom using a ross return.

b) Did not press the emergency bell following Patient H's fall.

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

Schedule 1

Patient E
Patient J
Patient Q

Background

You were referred to the Nursing and Midwifery Council ('NMC') on 12 July 2023 by Norfolk Community Health and Care NHS Trust ('the Trust'), following concerns arising during your employment at Caroline House, Colman Hospital, and Alder Ward, Norwich Hospital ('the Hospital). The referral led to an NMC investigation into a series of incidents occurring between April 2022 and February 2023.

You commenced employment with the Trust on 3 March 2022 as a Band 4 pre-registration nurse and was admitted to the NMC register on 10 June 2022,

thereafter, working as a Band 5 registered nurse. You began working at Caroline House on 4 April 2022.

During your probationary period, repeated concerns were raised by your colleagues and manager regarding your clinical practice including failure to follow care plans, unsafe and inappropriate manual handling, poor medication administration, inadequate record-keeping, breaches of infection control procedures, poor communication and failure to treat patients with respect. There were also allegations of falling asleep whilst on duty, failing to escalate patient falls appropriately, and providing inaccurate accounts of events following a patient's fall.

Despite multiple supervision meetings, probationary reviews, informal disciplinary discussions, and the setting of specific objectives and action plans, the concerns persisted across a range of clinical competencies.

You were suspended on 21 February 2023 and subsequently dismissed from the Trust on 10 July 2023.

Decision and reasons on application for hearing to be held in private

Mr Syed-Ali made a request that this case be held partly in private to allow him to name certain individuals whilst directing questions to Witness 2. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Simpeh indicated that she did not oppose this 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 certain individuals not connected to this case would be named, the panel determined to go into private session when these persons are named in order to protect their privacy.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Simpeh, on behalf of the NMC, to change a word in charge 3b).

The proposed amendment was to change the word '*international'* to *'intentional'*. She said the proposed change would provide clarity and more accurately reflect the evidence.

> "That you, a registered nurse:
>
> 3) During a night shift on the 4 and 5 May 2022:
> a) ...
> b) Did not complete patient ~~international~~ **intentiona**l rounding care documents and/or handover documents.
> c) …

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

Mr Syed-Ali submitted that you did not oppose this change.

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 an amendment, as applied for, 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 allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application for special measures in relation to Witness 8

Ms Simpeh made an application for special measures in relation to Witness 8. She informed the panel of the witness's health condition and requested that questions put to her be kept short and that she be allowed additional breaks at her request. Ms Simpeh submitted that this would support Witness 8 in giving her best evidence.

Mr Syed-Ali submitted that you did not object to this application.

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

Having heard about Witness 8's health condition, the panel determined to allow the application.

Decision and reasons on application to change your plea

Mr Syed-Ali made an application to change your plea as follows:

1a) - from accepted to not accepted;
8b) - from not accepted to accepted;
17c) - from accepted to not accepted;
19aii) - from not accepted to accepted; and
19b) - from not accepted to accepted.

Mr Syed-Ali submitted that these changes are made in good faith, at an appropriate stage of the hearing, and that no unfairness arises to the NMC in permitting the requested changes. He submitted that allowing the changes will assist the panel in focusing on true areas of dispute and those matters that are properly admitted.

Ms Simpeh submitted that she did not object to this application.

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

Having heard your application to change the plea on certain charges, the panel determined that this application would cause no unfairness to either party and determined to allow it.

Decision and reasons on facts

Mr Syed-Ali informed the panel that you made full admissions to Charges 3a), 3b), 4aii), 5a), 5b), 5c), 5d), 6bi), 6c), 7a), 7b), 8a), 8b), 12a), and 19aii), 19b).

The panel therefore finds charges 3a), 3b), 4aii), 5a), 5b), 5c), 5d), 6bi), 6c), 7a), 7b), 8a), 8b), 12a), 19aii) and 19b) 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 Ms Simpeh and by Mr Syed-Ali.

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

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

- Witness 1: Colleague B/ Ward Manager on the ward;
- Witness 2: Ward Sister on the ward;
- Witness 3: Ward Sister, on the ward;

- Witness 4: Ward Sister on the ward;
- Witness 5: Specialist Occupational Therapist;
- Witness 6: Healthcare Assistant on the ward;
- Witness 7: Registered Nurse on the ward;
- Witness 8: Healthcare Assistant on the ward;
- Witness 9: Rehabilitation Assistant on the ward;
- Witness 10: Healthcare Assistant/Colleague A;
- Witness 11: Patient B's husband;
- Witness 12: Person A/Patient D's partner;
- Witness 13: Occupational Therapist;
- Witness 14: Head of Clinical Education and Research.

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 also considered the witness and documentary evidence provided by both the NMC and Mr Syed-Ali on your behalf.

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

Charge 1a)

"That you a registered nurse

On 24 April 2022:

a) Used a hoist sling incorrectly while transferring Patient A."

This charge is found proved.

The panel considered the evidence of Witness 3 and your testimony, along with supporting material from the local investigation. It had regard to the account of Witness 3 who described hearing Patient A cry out in pain and entering the room to see Patient A sliding and falling from the wheelchair and that the hoist and straps had been used incorrectly. You stated that you did not recall this incident and deny this allegation.

The panel found the evidence of Witness 3 was clear, detailed, and consistent with her account at the local level. It had particular regard to the statement of Witness 3 where she stated, "I *asked Ms Igwe for the hoist control, and she refused, saying words to the effect of 'no, I've got this'*."

The panel was of the view that although you deny the allegation and deny using the hoist incorrectly, your lack of recollection of events does not amount to a rebuttal of a clear allegation.

Taking all of the above into account, the panel was satisfied, on the balance of probabilities, that you used a hoist sling incorrectly while transferring Patient A.

Charge 1bi)

"That you, a registered nurse, 24 April 2022:

Attempted to move Patient B contrary to her care plan in that you:
Did not have the assistance of a second member of staff."

This charge is found proved.

In reaching this decision, the panel had regard to your evidence and that of Witness 11 in respect of this allegation. In his live evidence, Witness 11 recalls being with Patient B so often that he knew the details of her care. He stated '*I have been with [Patient B] so often, I knew two nurses were always needed to put her in and out of bed. She was unable to walk alone, could not stand out of bed, it always took two of them*". He stated that he offered to help you, but you declined. You deny this allegation and state that you do not recall failing to obtain assistance from another colleague.

The panel noted that [PRIVATE] was unable to stand or mobilise independently. It had particular regard to the Falls MDT assessment which recorded that Patient B required assistance from two staff members.

The panel was satisfied that, taken in context, Witness 11's recollection of the incident was accurate in that you did not have the assistance of a second member of staff and attempted to move Patient B contrary to her care plan.

Therefore, charge 1bi) is found proved.

Charge 1bii)

"That you, a registered nurse :
Did not use a ross return"

This charge is found proved.

The panel carefully considered the direct and supporting evidence in relation to this allegation and was satisfied, on the balance of probabilities, that you did not use a ross return.

The panel had particular regard to the evidence of Witness 11, where he stated that Patient B required a ross return for transfers and that two staff members were always involved. This evidence was supported by Patient B's Falls Prevention Care Plan , which explicitly recorded the need for a ross return with assistance from two staff members.

The panel also considered your account in which you deny the allegation and could not recall the incident. In light of all the evidence, the panel found it more likely than not that you did not use a ross return when you attempted to move Patient B.

Therefore, charge 1bii) is found proved.

Charge 1biii)

"That you, a registered nurse, On 24 April 2022:

Pulled Patient B by her arm ."

This charge is found proved.

The panel considered all the evidence in relation to this charge.

The panel had regard to your denial of the allegation and your suggestion that you may have been mistaken for another nurse, as you were often mistaken for another black nurse. You also stated, '*I would never pull a patient by the arm'*. The panel also took into account the evidence of Witness 11, who gave direct and emphatic evidence that you pulled Patient B by the arm, causing her to cry out in pain and become distressed. He stated '…*that is absolutely what happened. She cried out in pain, my poor wife was so alarmed and confused*.'

The panel considered your denial of the allegation, your suggestion of mistaken identity and your statement: '*I would never pull a patient by the arm'*.

The panel found this explanation unconvincing in the circumstances. The panel was satisfied that Witness 11's account was accurate when taken in the context that he was involved in his wife's care and directly observed the incident.

Therefore, charge 1biii) is found proved.

Charge 1c)

"That you, a registered nurse, On 24 April 2022:

Told Patient B 'you lazy, get up' or words to that effect."

This charge is found proved.

The panel considered both Witness 11's evidence and yours**.** You deny this charge and state '*I would never speak to a person in this manner and those are not words I would use*.' The panel took account of the evidence of Witness 11 where he stated '*I am 100% certain she said it. I couldn't believe the nurse would speak to her like that. She had previously been treated with such kindness and civility*.' He also confirmed that you said this more than once and that the words were delivered in an aggressive manner.

When considering the evidence in the round, the panel was of the view that Witness 11 was clear consistent, and credible, and noted the distress he expressed when recalling the incident. It was satisfied that you made the comments as alleged while attempting to move Patient B.

The panel, therefore, finds this charge proved.

Charge 2a)

"That you, a registered nurse, on 25 April 2022:

Moved Patient B contrary to her care plan in that you did not have the assistance of a second member of staff."

This charge is found proved.

In reaching its decision the panel took into account all the evidence before it. It considered your evidence, Witness 6's testimony, and Patient B's care plan.

The panel noted your evidence that you did not recall this incident. It observed that this incident occurred the day after the matters in charge 1 and involved the same patient. The panel considered this to be relevant when assessing the likelihood of the allegation.

The panel heard the account of Witness 6 who stated that she informed you that it was unsafe practice to transfer Patient B without assistance, and you responded that she was taking too long to come and assist with the transfer.

The panel considered that on the balance of probabilities you moved Patient B contrary to her care plan.

Consequently, the panel finds this charge proved.

Charge 2b)

"That you, a registered nurse, on 25 April 2022:
Told Patient C to use their incontinence pad rather than assisting Patient C to use the toilet."

This charge is found proved.

The panel considered whether on 25 April 2022 you told Patient C to use their incontinence pad rather than assisting Patient C to use the toilet.

In reaching this decision, the panel considered all the evidence before it. It considered Witness 6's live evidence, where she stated that you were quite confrontational and point blank refused to put Patient C on the toilet. The panel note that Patient C had capacity and had expressed a clear wish to use the toilet.

It also considered your live evidence where you stated that he had already begun to use the pad and that *'… you did not want to interrupt his flow.*' The panel therefore determined on the balance of probabilities that you told Patient C to use their incontinence pad rather than assisting Patient C to use the toilet.

Given these findings, the panel finds this charge proved.

Charge 2c)

> "That you, a registered nurse, on 25 April 2022:
> While responding to a safety alarm, pulled Patient K by her arm."

This charge is found NOT proved.

In reaching its decision the panel took into account all the evidence before it. It had particular regard to the live evidence given at this hearing.

The panel heard your live evidence, where you stated that you were steadying the patient rather than pulling her.

The panel had regard to the evidence presented at this hearing and considered that there was insufficient evidence to establish this charge. It was of the view that, other than your reflective account, which you were persuaded to make at the local level, there was no independent or corroborative evidence that indicated Patient K was pulled by the arm. The panel concluded that the NMC had not discharged its burden of proof.

Accordingly, the panel finds this charge not proved.

Charge 3c)

> "That you, a registered nurse, during a night shift on the 4 and 5 May 2022: Left Patient L in a wet bed after answering the patient bell."

This charge is found proved.

The panel had regard to your evidence and that of Witness 3 in determining this allegation. Witness 3 stated that you answered the call bell and then returned to the office. That another colleague responded to the call bell when it rang again and discovered Patient L in a wet bed. She stated that when you were asked if he was on a wet bed when you answered the bell you responded yes. On further questioning you said you could not find anyone to help you.

You deny this charge and inform the panel that you went to find help and '*as usual'* help was not forthcoming. You stated, '*I may have carried on with other duties and may have forgotten about that one*'. You provided some context to the panel, stating that it was frustrating and you were always isolated as most people were always busy or gave you excuses when you asked for assistance.

Having weighed the evidence, the panel was satisfied, on the balance of probabilities you did leave Patient L in a wet bed after answering the patient bell.

Therefore, charge 3c) is found proved.

Charge 4ai)

> "That you, a registered nurse, did not communicate effectively with Patient A during therapeutic wash and dress sessions in that you:
> On 13 May 2022:
> Stated 'If you ask Patient A she will tell you the wrong thing' or words to that effect."

This charge is found proved.

The panel carefully considered the records from the local investigation alongside oral and written evidence, in determining this charge**.** You denied this charge and stated that Witness 5 may have misunderstood you. You informed the panel that you felt unsupported during this period where you state you felt you were still learning.

The panel had particular regard to the email from Witness 5 to Witness 1 dated 16 May 2022, in which she stated: *"she was talking to and over Patient A saying things like 'if you ask Patient A she will tell you the wrong thing' and 'this will take ages'."* The panel accepted this message as direct and contemporaneous evidence of your use of language consistent with the charge.

The panel found Witness 5 to be a credible and reliable witness. She attributed the words directly to you and described their negative impact on Patient A, including exacerbating her behaviour.

The panel was satisfied that the evidence of Witness 5 accurately reflected the incident described in the charge. Charge 4ai is therefore found proved.

Charge 4b)

"That you, a registered nurse, on 9 August 2022 laughed at Patient A ."

This charge is found proved.

The panel considered the evidence presented in relation to this charge and the context in which it was raised. It reviewed the email from Witness 1 to you dated 12 August 2022 as well as Patient A's Behavioural Chart contained in the case bundle.

The panel had regard to the evidence of Witness 9, who stated that you laughed at Patient A during a wash and dress, triggering a negative response from the patient. This account was supported by Patient A's Behavioural Chart which recorded the patient stating as follows: "*Its not funny why are you laughing at me when I am in pain*." The panel also took into account the email from Witness 1 to you, which

recorded that you had stated that you sometimes laugh when you do not understand what people are saying.

In oral evidence you denied laughing at Patient A and explained that Patient A had been verbally and physically abusive towards you, calling you the *'b word'* and scratching you. You stated that you smiled in response to being called the '*b word*' as you did not know how to react.

Taking all the evidence into consideration, the panel was satisfied on the balance of probabilities that you laughed at Patient A.

This charge is therefore found proved.

Charge 6a) and 6bii)

"That you, a registered nurse, On 22 May 2022 in relation to Patient D:

After being told by Person A that Patient D needed the toilet, you poked Patient D's crotch and said words to the effect of 'you have a pad on for that'.

Moved Patient D contrary to his care plan in that you:

i) …

ii) Pulled Patient D's right arm."

These charges are found proved.

Given the similarity of the allegations, which took place on the same day and involved the same patient, the panel considered charges 6a and 6bii together.

The panel had regard to the live evidence of Witness 12/Person A, whom it found to be compelling, credible, and reliable witness. She gave a clear and direct account of observing your interactions with Patient D, including you poking Patient D's crotch area and referring to his incontinence pad, and pulling Patient D's arm. The panel was satisfied that she had a clear recollection of events and had no motive to

exaggerate the events of that day. [PRIVATE] It also noted the description from Witness 12 of the distress caused to Patient D and the indignity of the situation.

The panel carefully considered your evidence. In relation to charge 6a, you denied poking Patient D's crotch, however, the panel noted that in your reflective account dated 21 May 2022, you stated "*I gently touched the pad to find out if it was soaked or not while asking to know the situation if he has used the pad or could use the pad.*" The panel considered this to be materially inconsistent with your later denial and found that you had provided differing accounts at different stages of the process. The panel concluded that this undermined the reliability of your evidence.

In relation to charge 6bii, you denied pulling Patient D's arm in your witness statement. However, in your live evidence you stated, '*I may have pulled the patient's arm in the process of transferring because I was alone.*' The panel regarded this as a significant concession which supported the allegation.

Having weighed all the evidence, the panel was of the view that on the balance of probabilities you did poke Patient D's crotch and made the alleged comment and that you pulled Patient D's right arm during the transfer.

Accordingly, both charge 6a and 6bii are proved.

Charge 9)

> "That you, a registered nurse, on an unknown date in August 2022, in respect of Patient O, attempted to reinsert a used catheter which had become unsterile."

This charge is found NOT proved.

In reaching its decision, the panel considered the evidence before it, your account, the documentary material, and the internal investigation records.

The panel noted that you have consistently denied this allegation. In addition, you stated that the Occupational Therapist had accidentally dislodged the catheter and that, in a moment of panic, she passed it to you and asked for assistance. You accepted that you briefly contemplated reinserting the catheter but decided against doing so.

The panel had sight of the email from Witness 1 to you dated 5 August 2022 confirming this account. The panel noted that there was no evidence to demonstrate that you made an actual attempt to reinsert the catheter.

In light of the evidence heard and the lack of supporting or contemporaneous evidence, the panel was not satisfied, on the balance of probabilities, that the conduct asserted in charge 9 occurred as described.

Accordingly, the panel finds charge 9) not proved.

Charge 10)

"That you, a registered nurse, on 26 August 2022 left Patient P in a wet bed."

This charge is found proved.

In reaching this decision, the panel took into account of all the evidence before it. It had regard to the evidence of Witness 6 who stated that she asked you to change Patient P and to call a colleague to assist you. She informed the panel that when she went to check on the patient, she found the patient still lying in a wet bed.

The panel considered your account that you could not undertake a task that requires assistance unless assistance was available, stating, '*if I don't find assistance, then I don't do the job.*' The panel found this account consistent with the account provided by Witness 6.

The panel noted that Patient P was an elderly patient [PRIVATE], making timely care particularly important. The panel also noted the recurring theme of lack of assistance

in the charges it had already found proved. It was of the view that, notwithstanding your explanation, Patient P was left in a wet bed for some time.

Therefore, the panel found charge 10 proved.

Charge 11a)

> "That you, a registered nurse, on an unknown date between 4 April 2022 and 19 December 2022:
>
> Having been told by Patient F that he did not want to be fed anymore, pushed the spoon into Patient F's mouth."

This charge is found proved.

The panel considered the evidence presented in relation to this charge and the context in which it was raised. It heard evidence from Witness 6 who stated that she observed you continue feeding Patient F after he had indicated he did not wish to eat and became visibly distressed.

The panel took account of your witness statement in which you denied the allegation. However, in oral evidence, you stated that you stopped feeding the patient once he refused to open his mouth. The panel noted this inconsistency in your accounts.

The panel also considered Patient F's Nutritional and Swallowing Care documentation, which supported the need for careful feeding practices. Having weighed the evidence, the panel concluded that it was more likely than not that you continued feeding Patient F after he refused.

Charge 11a) is therefore found proved.

Charge 11b)

"That you, a registered nurse, on an unknown date between 4 April 2022 and 19 December 2022:

Attempted to force feed Patient I."

This charge is found proved.

The panel considered the evidence of Witness 6 who stated that she observed you feeding Patient I with a tablespoon. Despite being advised to use a teaspoon, you continued using the tablespoon, and Patient I was observed hitting you away.

You deny this allegation and state that you would never force feed a patient even though you do not recall the incident. The panel noted that Patient I was a frail elderly patient with a high risk of choking. It considered that whilst you do not recall the incident, Witness 6 was clear in her account of the incident as she observed.

Given the evidence before it, the panel concluded that on the balance of probabilities you attempted to force feed Patient I contrary to guidance amounted to force feeding.

Charge 11b) is therefore found proved.

Charge 12b), 12c) and 12d)

"That you, a registered nurse, on 21 October 2022:

a) ...
b) Administered Olanzapine to Patient E crushed rather than orally.
c) Administered water and medication via an enteral tube to Patient J too quickly.
d) Continued to feed Patient R via an enteral tube after laying the patient flat in bed."

These charges are found proved.

The panel considered Charges 12b, 12c, and 12d together as they arose during the same medication round supervised by Witness 3. The panel placed significant weight on the fact that Witness 3 was observing you and completing records as the round progressed.

In relation to charge 12b), Witness 3 stated in evidence that you did not read Patient E's drug chart correctly and crushed Olanzapine despite it being prescribed for oral administration. You deny this allegation in your witness statement and stated in oral evidence that you did not recall the incident, although you accepted that it may have occurred. The panel preferred the account of Witness 3 and found it more likely than not that the medication was administered incorrectly.

Regarding charge 12c), the panel heard evidence from Witness 3 that you administered water and medication via Patient J's enteral tube too quickly and appeared to *'fire'* it through. In your live evidence, you stated that the speed of administration was a matter of perspective and referred to your personal experience in your home country but accepted that you slowed down when prompted. The panel found that this amounted to an acknowledgement that the initial administration was too fast and concluded, on the balance of probabilities, that the charge was proved.

In respect of charge 12d), Witness 3 stated that you laid Patient R flat in bed and continued enteral feeding, creating a risk of vomiting and aspiration. Although you do not recall this incident, you accepted in evidence that patients should be positioned at a 45 degree angle during feeding. The panel again preferred the contemporaneous evidence of Witness 3 and was satisfied that the feeding continued after the patient had been laid down flat.

Taking these matters together, the panel concluded that the evidence demonstrated a pattern of unsafe practice during the medication round on 21 October 2022.

Accordingly, the panel found charges 12b), 12c), and 12d) proved.

Charge 13)

"That you, a registered nurse, on or around 24 October 2022 did not wear sterile gloves whilst changing Patient S's dressing."

This charge is found proved.

The panel considered the evidence of Witness 8, who stated that she sought assistance from another nurse due to concerns about your competence. On returning, Witness 8 observed that you had changed Patient S's dressing and had not used sterile gloves. When asked how she knew you had not changed gloves, Witness 8 responded that she could see faeces on the gloves.

You stated in your witness statement that you did not recall the incident and asserted that sterile gloves were not required for changing the dressing for Patient S's wound. However, in your live evidence you stated that you did change your gloves although they were not sterile.

[PRIVATE]. It concluded that in light of the evidence before it, you did not use sterile gloves when changing the dressing.

Charge 13 is therefore proved.

Charge 14a) and 14b)

"That you, a registered nurse, on 25 October 2022 failed to follow Patient D's care plan in that you:

Did not sit Patient D fully upright.

Attempted to stand Patient D up without the assistance of a second member of staff."

These charges are found proved.

The panel considered charges 14a) and 14b) together as they arose from the same episode of care involving Patient D on 25 October 2022.

In relation to charge 14a), the panel had regard to the evidence of Witness 5, who observed Patient D slumped in bed during breakfast while being assisted by you. Witness 5 explained that Patient D was a '*red tray patient'*, required 1:1 support, and needed to be positioned at approximately 45 degrees for safe feeding. The panel also took account of Witness 5's email to Witness 1 dated 26 October 2022, reporting the incident, and Patient D's care plan, which advised that he should be sat upright. Although you deny the allegation in your witness statement and stated in oral evidence that you did not recall the incident, the panel preferred the account of Witness 5 and found it more likely than not that Patient D was not fully sat upright.

Turning to Charge 14b), you deny the allegation in you witness statement, stating that you were working with the Occupational Therapist and that there was a lack of communication as to positioning. However, in your oral evidence, you accepted that you were still learning and acknowledged that you may have acted in haste and attempted to stand Patient D up on your own. The panel considered that this account aligned, at least in part, with the evidence of Witness 5.

Taking the evidence in the round, the panel concluded that it was more likely than not that you failed to follow Patient D's care plan by not positioning him correctly and attempting to stand him without appropriate assistance.

Accordingly, charges 14a) and 14b) are found proved.

Charge 15a), 15b), and 15c)

"That you, a registered nurse, on 9 November 2022:

a) Required prompting to administer medication to Patient T.
b) Did not wear gloves to administer a Dalteparin injection to Patient U.
c) Required prompting to sign Patient V's drug chart after administering their medication."

These charges are found proved.

The panel considered charges 15a), 15b) and 15c) together, as they arose on the same day and concern your medication administration practices.

In relation to charge 15a, you stated that you did not recall the incident. The panel heard evidence from Witness 3, who stated that during the medication round you omitted one medication and required prompting to administer it. You stated that you are a slow learner and informed the panel that you did not have enough clinical supervision. The panel found Witness 3's evidence to be clear, consistent, and reliable, and accepted it to represent the facts of the charge.

Regarding charge 15b, Witness 3 gave evidence that you did not wear gloves when administering a Dalteparin injection and explained that gloves should be worn as an additional safety barrier to reduce the risk of needlestick injury. You maintained in both your witness statement and oral evidence that gloves were not required for subcutaneous injections unless the patient had an infectious condition and that handwashing was sufficient. You also stated that gloves do not prevent needlestick injuries. The panel concluded that your account aligns to some extent to that of Witness 3 and found that you administered the injection without gloves.

In respect of charge 15c), the panel again relied on the evidence of Witness 3, who stated that you required prompting to sign Patient V's drug chart after administering medication. Although you did not recall the incident, you accepted in oral evidence that drug charts should be signed immediately after administration. The panel found the evidence of Witness 3 to be more credible and consistent and accepted it.

Taking these matters together, the panel found these charges all proved.

Charge 16)

> "That you, a registered nurse, on 30 November 2022 incorrectly told Colleague A that Patient W did not require 1:1 care."

This charge is found proved.

The panel heard evidence from Witness 10/Colleague A that Patient W required 1:1 care and direct supervision at all times due to a high risk of falls. Witness 10 described an interaction at approximately 15:00 when you approached her and said '*lets go'*. When Witness 10 explained that she could not leave the patient due to the 1:1 requirement and the need to handover, you repeatedly insisted that the patient was not 1:1 and repeatedly struck Witness 10 on the back in a jocular manner with a document.

You stated that the 1:1 status was being reviewed that afternoon and that you wanted Witness 10 to confirm if there had been any changes to the patient's status. The panel noted, however, that despite the review, the care plan remained 1:1.

The panel concluded that the evidence of Witness 10 aligned more closely with Patient W's care plan and that you incorrectly informed your colleague that Patient W did not require 1:1.

Charge 16 is therefore found proved.

Charge 17a), 17b) and 17c

"That you, a registered nurse, on 13 December 2022 in relation to Patient G:

a) Failed to follow the patient's manual handing care plan in that you attempted to transfer Patient G without the assistance of a second member of staff.

b) Told Colleague B that another member of staff had assisted you to transfer the patient when they had not.

c) Failed to complete a post fall care plan and/or Datix."

These charges are found proved.

The panel considered charges 17a, 17b and 17c together, as they arose from the same incident in the patients' lounge on the ward involving Patient G on 13 December 2022.

In relation to charge 17a, the panel heard evidence from Witness 7, the nurse in charge of the shift. Witness 7 stated that you sought assistance to weigh Patient G but insisted on proceeding despite being redirected to other tasks. Witness 7 then left to confirm if Patient G had been weighed, was distracted and later heard a loud noise. She returned to find Patient G on the floor.

You provided several contradictory accounts of the incident. In one account you stated that Witness 7 was sitting behind the patient, in another account, that she was near the games table, in a further account that Witness 7 walked past the patient and stood a few metres behind the patient. In your witness statement you stated that Witness 7 was approximately 1 metre behind the patient who was sat in a chair. However, in evidence you stated that this patient uses a walking frame but at the time it was not near him. You stated that you were setting up the scales when the patient suddenly and unexpectedly stood up without assistance to sit on the scales and fell onto his side. This was contradicted by Witness 14, who concluded in her investigation report "*it is very unlikely that the patient at the time of the incident was able to stand on their own and had never previously tried to do so*"

The panel noted the multiple inconsistencies in your various accounts of the incident, particularly with regards to Witness 7's location at the relevant time. The panel also took into account that Patient G reported to Witness 1 during the local investigation that only one member of staff was involved in his transfer. Having regard to these matters, and the discrepancies in your evidence, the panel concluded that it was more likely than not that you attempted to transfer Patient G without the assistance of a second member of staff, contrary to the care plan.

Turning to charge 17b, the panel considered the evidence of Witness 1/Colleague B, who stated that you told him that another colleague had been assisting you with the transfer of Patient G to the seated scales. It noted the evidence of Witness 7, who stated that she was some distance away and only became aware of the incident

when she heard the fall. The panel also noted your later account, in which you stated that the patient stood up and attempted to transfer himself without assistance. The panel concluded that it was more likely than not that you informed Witness 1 that another colleague had assisted you when this was not the case.

In respect of charge 17c, the panel heard evidence from Witness 4 that you did not complete a Datix or post-fall care plan following the incident. You stated that you did complete the post-fall care plan the following day when prompted and that you did not complete the Datix because you believed Witness 1 would complete it on your behalf as he said he would. The panel noted that the responsibility for completing incident documentation rested on you as the nurse involved in the incident. It was of the view that while one of the required documents was only completed when prompted, the other was not as you relied on another colleague to do so on your behalf. In these circumstances, it found this charge proved.

Taking all the evidence in the round, the panel was satisfied that you acted contrary to Patient G's manual handling care plan, provided an inaccurate account to a colleague following the incident, and failed to complete appropriate post-incident documentation.

Accordingly, charges 17a, 17b, and 17c were all found proved.

Charge 18)

> "Your actions in charge 17 b) were dishonest in that you sought to create the impression you had transferred Patient G in line with their movement and handling care plan, when you knew you had not."

This charge is found proved.

The panel had regard to its finding in relation to Charge 17b in determining dishonesty. The panel first considered your actual state of knowledge and belief as to the facts and then whether your conduct was dishonest by the standards of an ordinary person.

The panel took account of the inconsistencies in your various accounts of the incident and contrasted this with the clear and consistent evidence of Witness 1, that you stated another member of staff had assisted you.

The panel preferred the evidence of Witness 1, when he said you represented that Witness 7 had assisted you to move Patient G, though it subsequently transpired that this was not to be the case. Further, Patient G, when asked confirmed that no additional member of staff had assisted you.

The panel was therefore satisfied that when you gave your account to Witness 1, you knew that no such assistance had been provided. By stating otherwise, you were dishonest, in that you sought to give the impression that the transfer had been carried out in accordance with Patient G's moving and handling care plan which indicated it required two staff members to move him.

The panel concluded that your actions were dishonest. Charge 18 is therefore found proved.

Charge 19ai)

"That you, a registered nurse, on 21 February 2023:

Failed to follow Patient H's care plan in that you:
Transferred Patient H without the assistance of a second member of staff."

This charge is found proved.

The panel had regard to Patient H's care plan, which clearly stated that transfers required the assistance of two members of staff and the use of a Ross return.

The panel had regard to the evidence of Witness 13 and Witness 14 who stated that the transfer of Patient H required the assistance of two. It also had regard to the

interview records and investigation report from the local level in relation to this charge.

You stated that prior to the incident Patient H required two staff for transfers but that, following reassessment by a physiotherapist, a summary display on the wall by the patient's bed indicated only one member of staff was required.

The panel noted that no updated care plan was produced to support this assertion and that the formal care plan remained in place at the relevant time. Accordingly, the panel found it more likely than not that you transferred Patient H without the assistance of a second member of staff, contrary to the care plan.

Charge 19ai, is therefore found proved.

Decision and reasons on application to revisit findings on facts

Mr Syed-Ali made an application inviting the panel to revisit three matters arising from its determination on facts.

First Mr Syed-Ali identified a typographical error at page 18, where reference was made to charge 1b) instead of charge 1bii).

Secondly, in respect of charge 18, Mr Syed-Ali submitted that the panel's findings did not adequately address the evidence relating to Witness 7. He submitted that there had been no proper discussion on whether you held the genuine belief that Witness 7 was present and available to assist with Patient G. Mr Syed-Ali invited the panel to review its findings on charge 18.

Thirdly, in relation to Charge 19ai), Mr Syed-Ali submitted that the factual basis of the charge had not been established. He submitted that page 106 of the witness statement bundle confirmed your assertion that the white board above the patient's bed indicated a "*Ross + 1 (RSA +2)*" for all members of staff to see.

Ms Simpeh submitted that with regards to page 18, this was a typographical error capable of correction.

In regard to charge 18, Ms Simpeh submitted that the panel had already properly considered the subjective element of dishonesty in relation to the charge and had reached its findings based on the evidence as a whole.

In respect of charge 19ai) Ms Simpeh accepted that the evidence of Witness 13 referred to a Ross +1 requirement being displayed on the white board above the patient's bed and acknowledged that there appeared to be some inconsistencies within the falls care documentation.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application.

In respect of the first issue, the panel was satisfied that the matter identified amounted to a typographical error. This was a practical issue and did not affect the substance of the panel's reasoning. The panel determined that the clerical error would be corrected.

In relation to charge 18, the panel was satisfied that it had already properly directed itself to the relevant evidence, including your multiple disparate accounts and the evidence it preferred from Witness 1. The panel concluded that no error had been identified that would justify revisiting its findings.

In respect of charge 19ai, the panel was satisfied that its findings were supported by the evidence as a whole and that no new matter had been raised which undermined its original conclusion. It was of the view that in the absence of any evidence demonstrating that the care plan had been formally reviewed, amended, or superseded, the panel was satisfied that the care plan remained operative and binding at the time of the incident.

Accordingly, the panel concluded that any information which may have appeared on the whiteboard could not properly displace the requirements set out in the care plan

which should have been properly read, understood and adhered to by nursing staff. Therefore, its findings in relation to charge 19ai remains unchanged.

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.

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

- Witness 15: Your current line manager

- Witness 16: Former practice development nurse at your current workplace (responsible for your supervision and mentoring whilst on the 'supportive practice programme.'

The panel also heard evidence from you under affirmation.

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.'*

Ms Simpeh 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.

Ms Simpeh referred the panel's attention to specific areas of the Code where your actions amounted to misconduct.

1 – Treat people as individuals and uphold their dignity – in particular:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

2 – Listen to people and respond to their preferences and concerns, in particular:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

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

4 - Act in the best interests of people at all times

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

8 – Work Cooperatively

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

10 – Keep clear and accurate records relevant to your practice

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

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

13 – Recognise and work within the limits of your competence

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

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

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

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

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

20: Uphold the reputation of your profession at all times

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

Ms Simpeh submitted that the incidents referenced in this case concerned vulnerable patients, involved repeated failures to follow care plans and policies, placed patients at unwarranted risk of harm, and fell short of the standards of conduct expected among medical practitioners.

Ms Simpeh submitted that although a breach of the code will not always result in a finding of misconduct, in this case the breaches were serious in nature and therefore the panel can properly find each charge which has been proved to amount to misconduct.

Mr Syed-Ali submitted that as the facts are found to be proved in all but 2 charges, the relevant consideration before the panel today is lack of competence/misconduct.

Submissions on impairment

Ms Simpeh 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)*, R(on the application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) *and Fopma v GMC* [2018] EWHC 714 (admin).

Ms Simpeh submitted that impairment is a matter for the panel. She submitted that you have in the past placed patients at unwarranted risk of harm through failures in manual handling, medication administration, feeding, continence care and communication. Ms Simpeh submitted that Patients G and H suffered harm and that Patient A was placed at risk through the incorrect use of equipment and

inappropriate communication. Ms Simpeh submitted that these failures occurred despite clear, well-established polices and repeated warnings.

Ms Simpeh made submissions in relation to whether you would place patients at unwarranted risk in the future. She referenced the testimony of Witness 16 who gave brief details about an incident concerning the administration of intravenous medication, which resulted in an informal capability process. She submitted that in your evidence you did not appear to fully grasp what this concern related to, nor the significance of it. Ms Simpeh submitted that you had since been signed off for your medication competency and there have been no further incidents following your completion of the associated capability assessment in respect of this incident. Ms Simpeh submitted that it remains a relevant consideration for the panel in respect of whether there is a risk to patients in the future.

Ms Simpeh submitted that you acted dishonestly in respect of Patient G, by telling Witness 1 that you had assistance when you knew that you did not have assistance. She submitted that there have been no further incidents of dishonesty and thus in those circumstances it was for the panel to assess the extent of your reflection with regards to risk of future incidents and whether there has been sufficient remediation to remove the risk of repetition in respect of dishonesty.

Ms Simpeh submitted that there was no significant evidence which the panel heard to highlight any personal circumstances. Although Witness 3 in her evidence to the panel stated she believes your personal circumstances may have impacted your conduct. Ms Simpeh submitted that taking into account the fact that you were spoken to on various occasions and was supported by Witness 2, your personal circumstances were not such that they had adversely affected your ability to practise safely.

Ms Simpeh submitted that, although you have undertaken training, received supervision and demonstrated insight into your conduct, there is further work to be done. She submitted that there was not sufficient insight demonstrated in respect of the importance of following policies.

Ms Simpeh submitted that this is a case where a finding of impairment is necessary to uphold proper professional standards and to maintain public confidence in the profession. She submitted that in this case, your conduct placed patients at unwarranted risk of harm and in the case of Patient G and H, your conduct resulted in causing them harm. She further submitted that your conduct was repeated, despite previous warnings and training being provided.

Ms Simpeh invited the panel to find that you are currently impaired on both public protection grounds and in the public interest.

Mr Syed-Ali submitted that you are not currently impaired. He submitted that the last incident occurred on 21 February 2023 and that you have since been subject to a prolonged period of scrutiny, including interim conditions of practice which remained in place until January 2025. He submitted that since the expiration of those conditions, you have practised unrestricted and without criticism.

Mr Syed-Ali referred the panel to the live evidence of Witness 16, who described how you were recruited into the Supported Practice Programme and confirmed that you were subject to weekly supervision, reflective sessions, and challenged about practice standards.

Mr Syed-Ali further relied on the live evidence of Witness 15, and her testimonial dated 5 November 2025. He submitted that she explained the supported informal capability process you were placed on in relation to concerns raised about your working outside the scope of practise which you completed on the 21st of October 2025. Mr Syed-Ali submitted that Witness 15 explained that the concern was more about completing the competency and not about patient care and that this concern was not recorded as a failure.

Mr Syed-Ali submitted that you have regularly received feedback from patients and colleagues which effectively forms part of your reflective discussion exercise. He submitted that this clearly shows that the past concerns were addressed and given the high quality and intensive nature of service that you have provided during the last three

years it is highly unlikely that the conduct, that gave rise to the charges, would be repeated.

Mr Syed-Ali submitted that you have expressed that you are not proud of your past behaviour and recognised the impact of your actions on public trust in the profession. He submitted that you now fully appreciate and have trained on therapeutic communication and have given a very candid overview of what it constitutes.

Mr Syed-Ali invited the panel to consider that you have shown/demonstrated significant development identifying risk and remedied effectively against your failings: in the following categories:

a. Effective therapeutic communication with patients
b. Effective colleague to colleague communication
c. Effective Care plans for service users.
d. Record keeping.

Mr Syed-Ali invited the panel to consider, when determining whether there is impairment, the following factors:

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 bridge 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.

Mr Syed-Ali submitted that the answers to these questions must be informed by what the panel heard in evidence from Witness 15 and Witness 16 about how you were forthcoming about your mistakes. He submitted that this openness is significant and relevant to the finding of dishonesty and your mental state going forward. He invited

the panel to conclude as a matter of factual finding that answer to all four questions above regarding the risks going forward would be ‘no’.

Mr Syed-Ali urged the panel to find that you do not have an impairment going forward to merit a finding of sanction.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance (no.2) v GMC* (2000) AC 311 para.331D, *Calhaem v GMC* (2007) EWHC 2606 Admin, and *Fopma v GMC* (2018) EWHC 714 (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 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.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it was satisfied that the matters found proved in this case went well beyond isolated errors or lapses of judgment and amounted to misconduct.

These events culminated in a total of 47 charges found proved against you. They are far ranging and relate to issues of patient handling, generic patient care and well-being, medication management and in one instance, dishonesty. The matters also took place over a protracted period of time between the months of April 2022 and February 2023 in two different work environments. For these reasons the panel considered issues of misconduct on a thematic basis and grouped proven charges accordingly and as follows:

- Manual handling
- Medication Management
- Basic Nursing Care
- Dishonesty

Manual handling: (charges 1a, 1b, 1bi, 1bii, 1biii, 2a, 6bi, 6bii, 6c, 14a, 14b, 17a, 17b, 17c, 18, 19ai, 19aii, and 19b)

The panel was of the view that your actions at these charges amounted to a breach of the Code. Specifically:

"1 - Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

4- Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

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

To achieve this, you must:

14.1…

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

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

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

In its earlier decision on facts, the panel found 47 of the 49 charges proved and identified a significant theme of unsafe manual handling across 5 incidents spanning April 2022 to February 2023. The panel determined that you repeatedly failed to follow patient's individual moving and handling care plans despite having received appropriate training and considerable local management intervention. The panel were provided evidence that you repeatedly undertook patient care alone in circumstances where assistance was clearly required, which in one instance resulted in serious injury to a very vulnerable patient.

The panel rejected your assertion that you were unsupported by colleagues and could not secure their assistance to transfer patients properly. They found this was contradicted by consistent and compelling written and oral evidence from your colleagues. The panel attached weight to descriptions of your *"bristling", "gruff*" and *"aggressive"* manner when handling vulnerable patients. These patients were at their most fragile having suffered either significant injury or having to endure serious illness. The panel heard evidence from close family members of Patients B and D who described with real clarity your harsh words, rough handling and an overall lack of compassion for their loved ones.

The panel was particularly concerned by the incident on 13 December 2022, which resulted in actual harm to Patient G requiring emergency care. This was some eight

months after the first incident where you did not follow a patient's individualised moving and handling care plan. The panel noted that rather than learning from your earlier mistakes and near misses, your unsafe practices continued putting patients at risk of harm. The panel concluded that these charges represented fundamental breaches of the Code and demonstrated a sustained pattern of unsafe practice.

Medication management (5a, 5b, 5d, 12a, 12b, 12c, 12d, 15a, 15b and 15c)

The panel was of the view that your actions at these charges amounted to a breach of the Code. Specifically:

"1- Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 …

1.2 make sure you deliver the fundamentals of care effectively

10- keep clear and accurate records relevant to your practice

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

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

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

13 - Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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:

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely"

In respect of these charges, the panel found that you adopted a cavalier approach to drug administration, including whilst under direct supervision. The panel noted repeated failures to comply with medication policies and procedures such as:

- Leaving medication keys on the drug trolley;
- Administering medication via an enteral tube too quickly;
- Failing to sign medication chart until prompted;
- Requiring prompting to administer medication; and
- Failing to follow a prescription regarding how medication should be administered to a patient.

While the panel accepted that any one of these incidents in isolation may not necessarily amount to misconduct, taken together and occurring over a six-month period, they demonstrated a concerning disregard for policy and patient safety. The panel considered you take shortcuts thereby placing patients at risk.

Basic nursing care (charges 1c, 2b, 3a, 3b, 3c, 4ai, 4aii, 4b, 5c, 6a, 6c, 7a, 7b, 8a, 8b, 10, 11a, 11b, 13, 14a, 14b, 16)

The panel was of the view that your actions at these charges amounted to a breach of the Code. Specifically:

"1 - Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1treat people with kindness, respect and compassion

1.2make sure you deliver the fundamentals of care effectively

1.3…

1.4…

1.5respect and uphold people's human rights

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

5-Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1respect a person's right to privacy in all aspects of their care

6-Always practise in line with the best available evidence

To achieve this, you must:

6.1…

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

8-Work co-operatively

To achieve this, you must:

8.1…

8.2…

8.3…

8.4…

8.5 work with colleagues to preserve the safety of those receiving care

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 further heard from several witnesses, including relatives of patients in your care that your care to patients was characterised by behaviour that was unkind and harsh towards vulnerable patients who required basic nursing care to support them with their day-to-day needs. Those needs included the provision of personal care, assisting with toileting, help with feeding and support to move position and mobilise. The panel considered this to be fundamental nursing care.

The panel was satisfied on the basis of the charges found proved that you:

- Communicated inappropriately with/and about patients;
- Disrespected patient's wishes in respect to toileting needs;
- Failed to treat patients with dignity and respect; and
- Demonstrated a lack of compassion.

The panel placed particular weight on the oral evidence of relatives including Witness 11 who you made feel that he and Patient B were a nuisance and described you as "bristling", and Witness 12 who stated as follows: *"it was clear that Ms Igwe was unhappy about having to assist Patient D. She was huffing and puffing".*

Dishonesty (charge 18)

The panel was of the view that your actions at this charge amounted to a breach of the Code. Specifically:

"20-Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 …

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

The panel found that you acted dishonestly by providing misleading information to your line manager regarding whether you were assisted by a colleague at the time Patient G fell. The panel identified clear inconsistencies between your accounts at the local level, your written statement and your oral evidence. It concluded that you sought to cover up your failures and thereby abused your position of trust.

Taking all of the above into account, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, 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* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel noted that issues relating to a failure to follow policy and procedure have persisted at your current workplace and almost up to the present day. In this regard, the panel considered the evidence of Witness 16, who when asked if you struck her as someone who follows the rules stated *'[you] wants to follow the rules but needs more support as opposed to someone who doesn't want to.*' While the panel accepted this evidence as genuinely held, it did not consider that this aspiration was reflected in your conduct.

The panel acknowledged the training you had undertaken since the incidents subject of charge, including the intensive Supported Practise Programme you completed, and the one-to-one mentorship provided in your current role. However, the panel attached significant weight to evidence that, despite this support, three further incidents occurred which demonstrated continuing characteristics of failing to follow procedures and working outside your scope of practice, with the potential for harm to patients. These included:

- administering intravenous medication
- undertaking intravenous cannulation

Both these matters occurred in recent months and amounted to you carrying out clinical procedures which you were well aware you were not qualified to do. You were immediately reported by a colleague, who knew you were not competent to carry out these procedures. This resulted in informal capability proceedings at a local level

which only concluded in October 2025. The panel find this demonstrates a prevailing propensity for you to ignore the rules, irrespective of the risk to patients, if it suits your purpose. The panel found your oral evidence around these matters to be deliberately vague and lacked any comprehension of the risks involved.

- providing care to a paediatric patient outside of your scope of practice.

This matter again only occurred in recent months and once more reinforced to the panel how you apparently fail to appreciate the importance of firstly understanding and thereafter following policy and procedure, and how failings in this regard can directly impact patient safety. On this occasion you were left with the care of a young baby (a patient) which is outside your current scope of practice. When questioned by the panel on your reflections you said '…*to double check my jurisdiction of practice, keep emotions, not act with impulsion and follow policies*' and admitted that you had operated outside your scope of practice and that you should have followed policy.

In addition, the panel heard from Witness 15 of a further, and ongoing matter whilst you were employed on a different ward in a bank nurse capacity. It is alleged you failed to follow accepted procedure in respect of oxygen administration to a deteriorating patient. This matter was escalated to your line manager Witness 15 by your supervisor at the time. Witness 15 confirmed there are no prevailing capability concerns surrounding this issue. However much as the panel accepts there is no formal complaint and a wider investigation does not directly involve you, they did consider this incident to be indicative of your previous behaviours. Specifically, your failure to seek appropriate guidance when incidents occur.

The panel was not persuaded that there was sufficient evidence to demonstrate that you had strengthened your practice in any meaningful or sustained way. The panel finds that patients were put at risk and were caused physical and emotional harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel identified a concerning pattern of you failing to learn from either your mistakes, or management interventions. Specifically, they noted the time period

between the incident with Patient G and Patient H (subject of charges 17, 18 and 19). Patient G suffered a significant facial injury as a consequence of you failing to follow manual handling procedures and for which you were subject of immediate management investigation. You were formally interviewed on 2 February 2023 and yet within a matter of weeks, 21 February 2023 had again acted with a complete disregard for the care plan of Patient H. Similarly Patient H suffered a fall. The panel found this inability to learn from your mistakes, and worse a propensity to repeat them, of real concern.

The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered your reflective pieces, the training you had undertaken, your oral evidence and the oral evidence of witnesses. It concluded that you demonstrated limited insight. While the panel appreciated that you appeared to have some appreciation of your failures, it was not assured that this understanding translated into genuine insight into your conduct or its impact on patients and their relatives. The panel was concerned that your expression of remorse appeared reactive to specific incidents during the course of the hearing, rather than reflective of a deeper understanding of the seriousness of the misconduct. It further noted several discrepancies between the content of your witness statement and your oral testimony.

In a not dissimilar vein, the panel identified a distinct lack of candour in your response to many of these matters. As opposed to a frank, open and reflective approach once your shortcomings had been discovered the panel observed a prevailing tendency to blame others, mislead and deflect blame.

- Charge 2 a) you stated Witness 6 ‘was taking too long’
- Charge 3 c) ‘you could not find anyone to assist’
- Charge 4 ai) you said Witness 5 ‘misunderstood you’
- Charge 15a) you stated you ‘did not have enough clinical supervision’

- Charge 17 you sought to implicate Witness 7 to lessen the impact of your own failing
- Charge 17 you suggested Patient G had contributed to his own fall despite this being considered clinically unlikely by Witness 14 (and not mentioned by Patient G himself)

The panel was concerned by your lack of frankness during this current stage of the hearing. When asked whether there had been any further incidents at your current workplace within the last 12 months, you did not disclose relevant matters until confronted with the evidence of Witness 15 and 16. This further undermined the panel's confidence in your insight and candour.

In relation to dishonesty, the panel identified a pattern of behaviour giving rise to serious concern, including:

- a disparity between your oral evidence and your witness statement in relation to the charges;
- the inference that you must have been mistaken for '*another black nurse'* in relation to charge 1b) and 1c);
- denying the existence of any further medication administration issues at your current role, which were later revealed through the testimonial and oral evidence of Witness 15 and 16;
- selective recall of incidents, contrasted with detailed recollection of certain aspects of the same incidents;
- providing different accounts regarding the whereabouts of Witness 7 in relation to charge 17 on several occasions both in your written and verbal accounts; and
- a lack of duty of candour.

The panel concluded that these matters demonstrated deep-seated attitudinal issues, particularly in relation to honesty, openness and accountability, which are fundamental tenets of the nursing profession.

At the Trust where you currently work the panel noted an almost artificial work environment. One tailored to support your every development need and your conditions of practice but also one based on such close mentoring and supervision that you could not fail. Much as on the face of it this could be seen as a positive thing, in reality the panel found it served to disguise your underlying issues, of 'short cutting' and failing to follow procedure. You did not appear to learn from previous shortcomings. In fact, once away from this close programme of support your performance dipped within a short space of time and you found yourself on a performance improvement action plan for not following rules which you were well aware of. Rules which could have impacted patient safety.

The panel noted a significant proportion of your 31 months nursing career in the UK to date has been spent under close scrutiny either via an extended initial probationary period, an 18 month conditions of practice interim order (subject of these charges) or the Supportive Practice Programme with your current health trust. It appears that when this close supervision ends, your unsafe practice emerges.

The panel was of the view that the nature of the concerns found proved in this case is, in principle capable of remediation. However, it was not satisfied that it has been remedied. The panel is of the view that there is a risk of repetition given your limited insight, absence of demonstrated remediation, the persistence of similar concerns in a new workplace, and the identified attitudinal issues. 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 required given the seriousness of the concerns, the dishonesty involved, and the risk that public confidence would be undermined if a finding of impairment were not made

in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Simpeh referred the panel to the NMC Guidance (SAN-1) and submitted that the aggravating factors in this case include:

- A pattern of misconduct over a period of time
- Conduct placed people receiving care at risk of suffering harm
- Direct risk to people receiving care
- Repetition of misconduct
- Breaching duty of candour and being dishonest
- Attitudinal issues
- Lack of remediation

Ms Simpeh submitted that the mitigating features in this case include:

- Admissions made at the local level
- Cooperation with the process
- There have been some steps taken to remedy the concerns
- The reflections provided demonstrated some limited insight

Ms Simpeh reminded the panel that in considering sanctions, the proper approach is to start with the least severe sanction. She submitted that taking no further action would not be appropriate. Similarly, a caution order would not be appropriate as it could not be said that there is no risk to the public or to patients and the case is not at the lower end of the spectrum of impaired fitness to practise.

Ms Simpeh submitted that although the panel found that the concerns could be remedied, the seriousness of the concerns identified made a conditions of practice order unsuitable. She further submitted that a suspension order would not be appropriate in the circumstances as the regulatory concerns do raise fundamental questions about your professionalism.

Ms Simpeh concluded that the only appropriate order in this case is a striking off order.

Mr Syed-Ali submitted that this is a case where conditions of practice can be an appropriate and proportionate sanction having regard to the misconduct found proved.

Mr Syed-Ali referred the panel to a useful comparator case. He submitted that in the case of *Hanna Wisniewska v NMC* [2016] EWCH 2672 (Admin) the registrant faced six charges of dishonesty and was substituted on appeal with a period of suspension. Mr Syed-Ali submitted that your case is significantly less serious. He submitted that a single charge of dishonesty, arising from a one-off incident was found proved in your case. Mr Syed-Ali stated that the dishonesty in your case stemmed from a misrepresentation as to whether Witness 7 had assisted you with Patient G.

Mr Syed-Ali submitted that you have demonstrated remediation through successful completion of a supervised training programme. He emphasised the evidence of Witnesses 15 and 16 who directly supervised you during the relevant period. Mr Syed-Ali submitted that neither witness expressed any ongoing concerns regarding your practice. He submitted that there must be compelling evidence to displace the weight of Witness 16's evidence, particularly her statement that she would be content for you to care for her own mother. He submitted that her evidence is a powerful indication of professional confidence from a colleague with direct oversight of your practice.

Mr Syed-Ali acknowledged that the panel had correctly identified two incidents during the period of supervision at your current role, however, he noted that these matters were properly characterised as administrative issues and neither resulted in regulatory action.

Mr Syed-Ali submitted that conditions of practice would sufficiently address both the public protection and public interest elements in this case. He submitted that you have already demonstrated that you can comply with conditions and work safely under supervision. Mr Syed-Ali submitted that given your successful completion of the Supported Training Programme, the panel can be confident that any future conditions will be complied with. Mr Syed-Ali recommended that the panel contact your current employer to establish if any proposed conditions might be acceptable and workable.

Mr Syed-Ali submitted that if the panel is not satisfied with a conditions of practice order, a suspension order would be a proportionate alternative. He submitted that a suspension order would allow you time to undertake further reflective work, training, and professional development, and to demonstrate sustained insight and improvement.

Mr Syed-Ali concluded that your alleged conduct found proved in their totality does not amount to incompatibility with continued registration.

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 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:

Extreme vulnerability of patients

- The concerns found proved occurred on a neurological rehabilitation ward caring for patients suffering from serious illness or injury with complex rehabilitation needs;
- Many patients on the ward required two members of staff to ensure that their care needs were met in accordance with individualised care plans;
- Failure to follow those individualised care plans creating a real risk of serious harm;
- One vulnerable patient (Patient G) in this case suffered a significant injury requiring emergency care; and
- Patients on such wards are entitled to expect high-level care delivered with dignity, respect and compassion.

A pattern of ignoring policies, procedures and taking shortcuts

- The panel identified a sustained pattern of either a failure to understand procedures or a conscious disregard for policies and procedures;
- The concerns found proved in this case were not isolated events but rather repeated conduct over a protracted period, continuing even after training, supervision and management intervention;
- Panel observed that when supervision on your practice was reduced, the same concerns of deliberately taking shortcuts and not following procedures re-emerged;

- Your admission in oral evidence that you should have been following policy, you said you worked outside your jurisdiction and acted impulsively; and
- The panel heard in evidence of four separate incidents in the last year all of which exhibited similar characteristics of your propensity to disregard procedure and take shortcuts.

Lack of kindness and maintaining patient dignity

- A lack of professionalism in treating and communicating with patients;

A pattern of blaming others

- When concerns about your practice are raised, you seek to deflect responsibility onto colleagues or circumstances. This includes providing misleading accounts of events and a failure to take ownership of your actions.

Dishonesty

- Demonstrating a lack of candour in respect of reporting your role in the harm caused to Patient G;
- Attempting to cover up incidents by claiming mistaken identity; and
- A pattern of seeking to mislead those in authority when misconduct is discovered.

Repetition

- Concerns were repeated over several months in different clinical areas and involved multiple failings; and
- Failing to learn from your mistakes and near misses, despite feedback, additional training, mentoring and close supervision.

Departure from standards expected of a registered nurse

- You had extensive experience in your home country as a nurse and a midwife prior to your role at the Trust. You told the panel you had practised for 12 years before coming to the UK and in several specialist areas including ICU and midwifery. You were also subject of a not dissimilar regulatory nursing Code prior to working in the UK. Most of the charges proven related to basic nursing care, professionalism, honesty and kindness. The panel concluded that you were not new to the nursing profession. Providing basic nursing care is a fundamental expectation of a registered nurse irrespective of where that practice takes place.

Lack of timely remorse towards patients

- You only expressed remorse for your conduct towards patients at a very late stage of these proceedings.

The panel also took into account the following mitigating features:

- You were new to the UK healthcare system and may have experienced an initial period of adjustment at the outset;
- There was little by way of direction from the Trust, which could have positively impacted your early days, and your induction process could have been more structured;
- You made limited admissions and insight at the local level; and
- You have undertaken some training in respect of the concerns.

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 seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel was of the view that the concerns in this case are not limited to deficits in your clinical skill but involve deep-seated attitudinal issues, including repeated disregard for policies and a lack of candour. Importantly, the panel also noted that you had already been subject to an extended probationary period, a prolonged interim conditions of practice order and a prolonged and intensive supervision during the Supported Practice Programme for Registered nurses tailored for you at your current role during which your compliance with policies improved temporarily. However, once supervision eased, your unsafe behaviours, disregard for policies and procedures re-emerged within a short space of time. The panel therefore had no confidence that the placing of conditions on your registration would adequately address the seriousness of this case and protect the public.

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

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

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…; and*
- *...*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

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

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

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

Your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with 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 undermine public confidence in the profession and in the NMC as a regulatory body.

The panel was particularly concerned that your deep-seated attitude surrounding a propensity to deliberately disregard rules, continues to the present day. Indeed, the panel has heard of four matters in the last year where these unsafe patterns of

behaviour have prevailed. Your behaviour presents a continuing risk to patient safety.

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 herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

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 until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Simpeh. She submitted that, given the decision that your fitness to practise was impaired on both public protection and public interest grounds, an interim suspension order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

Mr Syed-Ali made no submissions in respect of this 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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decision to strike you off the register.

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

That concludes this determination.